S. HRG. 101-877

FISCAL YEAR 1991 BUDGET PROPOSALS

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

FEBRUARY 28, MARCH 6 AND 22, 1990

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

30-856 ±± WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S361-46

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FISCAL YEAR 1991 BUDGET PROPOSALS

WEDNESDAY, FEBRUARY 28, 1990

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:02 a.m. in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Rockefeller, Daschle, and Packwood.

[The press release announcing the hearing follows:]

[Press Release No. H-13, Feb. 26, 1990]

SENATOR BENTSEN ANNOUNCES HEARING ON 1991 BUDGET PROPOSED BY PRESIDENT BUSH—MEDICARE, MEDICAID, INCOME SECURITY, SOCIAL SERVICE PROGRAMS TO BE TOPICS

WASHINGTON, D.C.—Senator Lloyd Bentsen (D., Texas), Chairman, announced Monday that the Finance Committee will hold the first of three hearings on proposals for deficit reduction and spending initiatives contained in President Bush's budget for fiscal year 1991.

The hearing will be on Wednesday, February 28, 1990 at 10 a.m. in Room SD-215 of the Dirksen Senate Office Building. Dates of additional hearings will be announced later.

This hearing will examine proposals relating to Medicare, Medicaid, income security and social service programs under the jurisdiction of the Committee on Finance.

Louis Sullivan, M.D., Secretary of Health and Human Services, will be the only witness at this hearing.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. This hearing will come to order.

Dr. Sullivan, we are pleased to have you back with us, to discuss the administration's budget proposals for fiscal year 1991.

The Congressional Budget Office estimates that the administration's budget proposals would lower the payments for services under the Medicare Program by $5.2 billion, and of that total, $3.9 billion, approximately 75 percent of it as I understand it, would come from reducing payments to hospitals for inpatient and outpatient services. $1.2 billion of the total hospital cuts would come from reducing additional payments for teaching hospitals. About $990 million, or 19 percent of the cuts, would come from payments to physicians. Now the magnitude of those cuts is really of great concern to me. It must be to you. And that is particularly true when we think about the fact that the Medicare program has made substantial contributions to deficit reduction in the past years, and

when we remember the fights we had over this last year and the year before.

Last year's budget reconciliation bill alone reduced Medicare payments by $3 billion in 1990, $11.2 billion over 5 years.

I am just back this weekend from visiting Parkland Hospital in Dallas, talking to them, seeing some of the services they provide, hearing about some of the problems that they are incurring, and the kind of losses the administration's proposals would mean to caring for Medicare patients. And that story I heard in Parkland is repeated all over the country, as you know, Doctor.

I just cannot believe that cuts that size recommended by the administration are realistic. In fact, I am advised that over half of the Senate and 230 Members of the House have written letters to the President or to the Budget Committee chairman to state they do not wish to see big cuts in Medicare this year.

Many of the specific proposals that are included in the budget have been rejected by the Congress in previous years. And that includes cutting hospital capital payments by 25 percent, reducing the indirect medical education adjustment factor for teaching hospitals and requiring all State and local employees to contribute to Medicare.

So I believe that in spite of OMB's aspirations, $5.2 billion in Medicare cuts for 1991 is just not in the cards. I don't think it is going to happen and I certainly will oppose our going that far.

I know that Medicare, under the kind of budget constraints we face, is going to have to take its share of the cuts, but not to these extraordinary levels, in my opinion. I don't envy your job. I would assume—and you don't even have to nod your head—that you are not enthusiastic about having to defend these proposals. I am sure not enthusiastic about my responsibility as chairman in trying to guide these kinds of draconian cuts through the Senate. And I would doubt that my colleague over here on my left would be very enthusiastic either.

So I hope that we can work together to get some reasonable level of budget savings in the Medicare program, a level that doesn't bring about a major dislocation in the delivery of services to beneficiaries.

Now, Dr. Sullivan, the administration's budget also has some provocative proposals for restructuring the delivery of care, and these include the "Medicare Plus" recommendations and managed care for Medicaid patients. And I look forward to hearing more about these proposals from you today.

I hope we will be able to work with you on these initiative and with others where we share a long-term interest and that includes improved coverage of pregnant women and children under Medicaid. I want to continue to expand that and see what we can do to help.

I now defer to my colleague, Senator Packwood, for any comments he might have.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Secretary, I was intrigued in reading the little addendum on page 45 of your testimony, which was obviously added after OMB looked at it, in which you called for the additional 64-cent cigarette tax. [Laughter.]

The CHAIRMAN. You got my attention to that one. [Laughter.]

Senator PACKWOOD. I have said many times, Doctor, if I were king I know what I would do to the tax system. Whether it succeeded or not, I would be convinced that what I wanted to do with it was right. But if I were king and was told I could do anything I want to the medical reimbursement system, I don't know what I would do. I am not sure I know the answer.

I have seen the projections from CBO and OMB on what happens to Medicare if we do nothing. Within 11 years it exceeds Social Security in its outlay, and within 18 years—and this is before we talked about any possible peace dividend—it exceeds Defense and Social Security. I don't see how this country can afford to spend 12 to 15 percent of its GNP on medical care. But I don't know the answer. I am intrigued with some of the things you have in your statement. I don't think it is quite fair for us in the Congress to say, no, no, no, just because what you are suggesting in some areas may be controversial, or to some recipients may be painful. I don't think our answer can be just no, no, no. I wish I felt more confident that, of I said no to you, I would have an alternative to suggest. As the Lord knows, we have tried prospective payment systems, we have tried limitations on doctors' fees, we have tried a variety of things, and none of them seems to work as successfully as we hoped to reduce overall costs.

So I look forward with eagerness to what you have to say. I am willing to work with you. My mind is open on this issue. I wish I knew the answers.

The CHAIRMAN. Thank you.

Senator Rockefeller, would you care to make a comment?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman, I would, just a brief one.

Mr. Secretary, in a sense it is almost like a broken record, because each year we come back here, and the years that I have been here, Medicare has been cut enormously by the administration. We in the Congress have come back and tried to restore it. And I, like Senator Packwood, understand the difficulty. Medicare is an enormous program, a $100 billion program, growing at 17 percent a year. But we have sustained tremendous cuts in recent years, tremendous cuts, close to $20 billion just in the recent past. In West Virginia, our rural hospitals continue to close. They are losing an average of half a million dollars a year. And if your budget goes through, they will lose another $36 million and three or four more hospitals will have to close down.

So I express grave concern with that. Also with respect to the President's proposals for cutting physician payments in the admin-

istration budget, that troubles me deeply. Last year, many of us worked very hard to achieve physician payment reform to get a fee reimbursement schedule for physicians that was rational and predictable that would lean more toward primary care. And I think that would and did agree very much with that. It is a much more rational evaluation of the way physicians are paid through medical services. But on the other hand, in the President's budget, overvalued procedures are drastically cut, leaving really very little room to bring up the payments in some of these primary care areas that we are talking about.

So I criticize really not only on the merits of this whole thing but just the fact that it leaves it up to the Finance Committee and to the Congress to come back to try to restore at a time when it is most difficult, and instead of leading with strength, the President's budget has made our work much harder for us.

I worry so much that this proposal in fact could even undermine the support for our new physician payment reform bill. The medical community in fact signed on; it was willing to support it, reluctantly, with the assurances that would come about in the period of time, 1992 through 1996. And it was agreed upon. We phased it in for that reason. So all of these things I think are of great concern to me.

I know very personally of your own deep commitment to—a professional commitment and a personal commitment—to strengthening our health care system in America. I know that you want to expand access for our people, and I know that you want to help control costs just as I do. But I also hope that you can convey to the budget cutters at OMB that Medicare is more than just beds and syringes and numbers. It is what our people need, what they deserve, what we contract with them for in 1965. And this budget does a lot of damage, Mr. Secretary.

I thank the Chairman.

The CHAIRMAN. Mr. Secretary, if you would proceed.

STATEMENT OF HON. LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

Secretary SULLIVAN. Thank you, Mr. Chairman, Senator Packwood, and Senator Rockefeller.

It is a great pleasure indeed to appear before you again to discuss the priorities for the next fiscal year for the Department which I lead.

I would like to present a brief overview of the budget proposals under this committee's jurisdiction and submit for the record a more detailed summary of these proposals.

The CHAIRMAN. It will be accepted.

[The summary appears in the appendix.]

Secretary SULLIVAN. It has been almost a month since the President submitted his budget proposal to the Congress. And, now that the dust has settled, I hope that we can intensify our deliberations.

I believe that the American people would particularly benefit from a new openness in the discussion about the future of government health policy. And I seek a continuing dialogue with the

members of this committee who are all extremely knowledgeable about this issue.

As a physician, medical administrator and educator, I do know firsthand that there is room for improvement in the delivery of health services. Sometimes this means that we must spend more money on programs such as increasing the number of minority health professionals or promoting biomedical research or reducing infant mortality. But if we seek to meet those needs, we must also spend our money more wisely, particularly for government-financed health programs such as Medicare and Medicaid.

Last year, we took a major step forward in ensuring that our medical dollars go further by forging important reforms in the Medicare physician payment system. It is my hope that we can build upon those achievements this year. Because unless we take action to stem the growth in Medicare, which has doubled every 5 years since 1975, we will be in danger of not having the resources available to provide for our children's and our grandchildren's medical needs.

In the context of health policy, cost-effectiveness is not an obstacle to compassion, but rather could serve as its handmaiden. That is why I resolutely believe that the health reforms in our budget are so important. I realize that some of these proposals are not novel, but nevertheless I do believe they represent sound policy.

The Federal Government needs to encourage alternative methods of health care delivery which are becoming increasingly popular in the private sector. A preponderance of the evidence shows that managed care delivers quality health care in a cost-effective manner.

The President's 1991 budget works toward smart shopping for health services with three major initiatives in health care.

First, we would encourage greater use of managed care in Medicare and Medicaid.

Second, we would increase our focus on appropriateness of care by implementing a new program to evaluate medical technologies and practice patterns.

And, third, we would extend use of prudent purchasing principles to secure the best value for Medicare beneficiaries.

Let me emphasize that none of our Medicare legislative proposals would reduce benefits. Our budget proposals achieve savings through reforms that reduce costs for beneficiaries and taxpayers alike. For example, the proposals would reduce coinsurance that the elderly must pay by reducing excessive payment rates for certain physician and other part B services. Savings for seniors from lower copayments would total an estimated $375 million in fiscal year 1991 or about $1 a month per enrollee. These savings would nearly double by fiscal year 1992.

I believe that access to health care for the most vulnerable among us can also be enhanced by the application of reforms which are both cost-effective and compassionate. The budget contains important reforms in Medicaid which encourage the greater use of managed care systems.

I want to address another critical health care issue that deeply concerns the members of this panel, and that is long-term care and coverage of the uninsured and the underinsured.

As you all know, the President announced in his State of the Union address that he has appointed me to lead a domestic policy council review of recommendations in several health care studies underway. These studies include the U.S. Bipartisan Commission on Comprehensive Health Care, the so-called Pepper Commission, led by Senator Rockefeller, and the Advisory Council on Social Security, chaired by Deborah Steelman. I have also appointed a task force chaired by our Health and Human Services Under Secretary, Constance Horner, which is also working on this issue.

The Domestic Policy Council review and the work of the HSS task force are extremely important because it is critical to find ways to make our health care delivery system more effective and more efficient if we are to address the needs of those most vulnerable, as well as the needs of all Americans.

Quality, accessibility and cost are not a list of separate issues. They are indeed one issue.

As I conduct this review, I look forward to the cooperation of this committee, and others who are committed to improving the health of the Nation, to make the American people aware of the significance of this issue and their stake in it.

Health and Human Services also administers the Social Security trust funds. Social Security is certainly not broken and it does not need fixing, either by undermining the financial condition of the trust funds or by making ill-advised changes in the structure of the Social Security Administration.

I remain firmly opposed to separating the Social Security Administration from the Department of Health and Human Services. Such a proposal simply would not make sense from a management perspective nor, more importantly, from the standpoint of our beneficiaries.

Congress, including the members of this committee, have spent years weaving an intricate fabric of integrated Social Security, Medicare and other services to the elderly under the single roof of the Department of Health and Human Services. If the Social Security Administration were torn from HHS, that fabric of services would be ripped to shreds, disrupting services and increasing costs for many years to come. And the losers, Mr. Chairman, in this process would be the Nation's elderly.

For me and for this administration, nothing is more important than the proper management and protection of the Social Security trust funds. The President's 1991 budget proposes additional protection for future beneficiaries by addressing the issue of Social Security reserves and the deficit. The proposed Social Security integrity and debt reduction fund is a sensible approach to ensure that the Government will not spend Social Security receipts on non-Social Security purposes.

One of the major objectives of the programs under the roof of the Department of Health and Human Services is the strengthening of our Nation's families. As has been said, the family is the first and most effective health and human services organization.

With the enactment of the Family Support Act of 1988, the Reagan-Bush administration and the Congress, with the deep involvement of the members of this committee, took an important step forward in assisting low-income families to become financially

independent. For the job opportunities an basic skills training program, which represents one of the most fundamental reforms in the Act, the budget provides $1 billion. This is the maximum amount authorized by law and represents an increase of more than half a billion dollars over the amount we estimate will be spent in the current fiscal year.

In child welfare services and foster care, the administration's priorities are clear. We want to prevent unnecessary placement of children outside their families, to reunite children with their families or, when it is not in the best interest of the child, then to find permanent, loving homes for children through adoption. Our proposals reflect these priorities.

In closing, I want to express my fervent hope that, working with this committee, we can forge a compassionate and fiscally prudent budget.

Thank you, Mr. Chairman. That completes my statement. And I would be happy to respond to questions.

The CHAIRMAN. Thank you very much, Mr. Secretary.

Mr. Secretary, as I was mentioning earlier, I just returned from my State, where I was visiting with hospital administrators. And my State for the last 4 years has led the country in closing of hospitals many in rural areas. Senator Rockefeller was commenting on the problems of West Virginia in that regard. And last year I introduced legislation, joined by Senator Dole, Senator Baucus, and others on this committee, to close the basic Medicare rate differential between urban and rural hospitals, and asking your Department to come up with a proposal for getting that done by 1995. We also asked you to take into account severity of the illness, because some of the urban hospitals take on the patients with more serious problems, and treat the sickest patients in each of the DRG categories.

Now ProPAC, as I understand it, is recommending that the schedule be accelerated, and the differential eliminated by 1993. They would finance that by giving a smaller rate increase to hospitals in urban areas.

Do you have an estimate of the cost of eliminating that differential, and do you go along with the recommendation of ProPAC in that regard? How would you finance it?

Secretary SULLIVAN. Thank you, Mr. Chairman.

First of all, let me indicate that I certainly share your concern about maintaining access to health services for all of our citizens. We have taken note of the responsibility given to us by the Congress to come forward with a plan by October 1st for how we would close that differential. And we, indeed, will be coming forward with such a plan, on schedule. I believe the law requires this to be implemented, starting in 1992 and completed, as you have indicated, by 1995.

We do have in the interim, as you know, a number of programs to assist rural hospitals in the administration of their programs and in other initiatives. So we certainly look forward to working with you in doing everything we can to address the problems that our hospitals face, including closing that differential.

On the issue of the acceleration that, ProPAC has recommended, I would want to review that in some detail, Mr. Chairman. And not

having yet done that, I really could not comment further, except to say that we would certainly do everything we can and work with this committee to try and address that problem.

The CHAIRMAN. Well I really want to pursue this and I would like to have some early comments from you in regard to how you feel about ProPAC's recommended acceleration to 1993 and whether that is sufficient time to make changes in measuring severity of illness, how you would finance eliminating the differential. If we can move it forward in a logical progression, I want very much to do it because as I talked to these administrators out there in rural areas, they say, they don't know that they can hang on until then. I'm concerned about areas like Brewster, TX, which is 130 miles to a city of any size. And having to travel that far to a hospital is really an undue burden.

In the rural areas you have people that are generally older and incomes are generally less. So it is not something I think we can go at a slow measured pace about. I very much would hope that your Department can give me a response to that and give me an earlier one in detail.

Secretary SULLIVAN. We will be happy to get back to you with a response, Mr. Chairman.

The CHAIRMAN. All right.

I must say to you also that when I was at Parkland Hospital this weekend, they told me that the Texas Hospital Association reports that over 70 percent of the hospitals in my State are losing money on Medicare patients, 70 percent. They told me that if the administration's proposals were put in effect, Parkland would lose payments equivalent to the cost of treating 2,000 Medicare patients. What do you think hospitals should do? What kind of steps do you think they should take in trying to respond to those kind of cuts if they are enacted? Do those kind of reductions have any justification, other than cutting the size of the deficit?

Secretary SULLIVAN. Yes. There are a number of things Mr. Chairman, that our hospitals could do. One of the themes in our budget is to establish more prudent purchasing practices among our hospitals for a variety of services. We do know, for example, that some of the private sector organizations do have more efficient and prudent purchasing practices, as does the Veterans Administration. We think that is an example of how we could save money without compromising services. So we certainly are very concerned, as you are, about doing everything we can to see that essential services are preserved while we work on the other issue with you and the other Members of the Congress on controlling the rate of escalation of health care costs.

One other comment I would make is, as I indicated in my testimony, we will be leading the review of our comprehensive health system, which won't take care of this immediate problem. But certainly we do hope to come forward with some recommendations for the President, using the input from the Pepper Commission, our own internal task force, and the Steelman Commission, and others, to really try and develop a more rational system that will meet the access needs of our citizens, and assure quality while addressing the cost issue.

The CHAIRMAN. Well, Doctor, those comments are fine in general, but I surely want to get more specifics. I defer to my colleague, Senator Packwood.

Senator PACKWOOD. Doctor, let me ask you a philosophical question because all of us have concerns about rural health. There may be a State where it doesn't exist—I don't know if it does in Rhode Island, which is small enough so that it may not have a rural health problem—but it does in most of the States.

In January I conducted hearings on rural health in 11 towns in Oregon. The population of the biggest town was 10,000; two were less than 2,000. They all have a hospital at the moment. The 135 miles the Chairman mentioned is the exact distance you would have to go from one particular town to the next town that has a hospital if the first town's hospital were to close. And there is also a problem with doctors. One county had four doctors, one of whom is about to quit and go to a town 50 or 60 miles away to become an emergency room physician. There he will at least have regular hours and only work 12 hours a day instead of 18 hours a day. The burden that his departure will throw on the other three physicians will be extraordinary because they have been unable to recruit another physician.

One town was jumping with glee because they had recruited a physician who had been a Christian medical missionary in Africa. He had been there a number of years, was ready to come back, and wanted to be in a rural area, but that is an unusual situation.

I came away with one of two conclusions. If we are going to have rural hospitals, they are going to have to be subsidized. We cannot say they are going to make money. They aren't going to make money. We may also have to subsidize nurse practitioners, certified registered nurse anesthetists, and others going to rural areas. And you may say, well, we will close the hospital. But if you have an emergency, if you get into a car accident, we will have a helicopter from the big town come get you quickly and get you to a hospital there. Because there will be no hospitals in these small towns. And the unfortunate part of that is, for 90 percent of what rural hospitals do, they can do it perfectly adequately. But if a person has to go 100 miles for treatment, it is unfortunate for the kids and the spouse to have to travel that far to visit. I hope closing small-town hospitals is not the answer.

Philosophically, let me ask you first, do you agree that these hospitals are not going to make money? I don't know how they are going to make money. They will have to be subsidized one way or the other. Maybe through a rural tax base, if the voters will vote for it. Maybe through higher Medicare payments, where we simply give them more money. Or maybe through tax incentives to keep the physicians there.

So, first, do you agree that if we are going to keep rural hospitals they are going to have to be subsidized? Second, in your judgment, which way should we be going in terms of rural health care? Should we keep rural hospitals, or close them and somehow get the patients to the nearest medical facility?

Secretary SULLIVAN. Senator Packwood, in response to your first question, I think that there is no question that we are going to have to continue to provide support for our hospitals, both our

urban and our rural. And, of course, the review that we will be reporting to the President on, of course, will take those kinds of factors into consideration, because we are committed to maintaining essential access for our citizens.

Now, on the question of closure of rural hospitals I think that really has to be primarily a local decision rather than dictated by broad policy from Washington, because such a decision will take into account all kinds of factors such as what are the transportation times to the nearest available facility?

Certainly we are committed to the proposition that essential services have to be available to our rural citizens, but specific decisions take into account those local factors so that there reasonable access is available.

Senator PACKWOOD. Except, Doctor, that the decision is local only in this sense. If the reimbursement from the Federal Government for Medicare—and these hospitals have a disproportionately high Medicare load because there is a disproportionate number of elderly in rural areas—is such that they simply cannot make money, they are forced to lose money on their Medicare patients. And these hospitals are pretty good; they take anybody. The decision to close is not really a local decision, then. If the Federal Government is not helping rural hospitals pay their way, they are going to close.

When you say is it a local decision, it is true that most of these are tax based hospitals, and they have a tax base. But at some stage the local citizens reach a point where they say, we can't afford to pick up what we are losing on Medicare, and rural hospitals close.

If that is going to be the decision, then lots of other things will flow from it. You won't have to worry about attracting doctors to the rural areas, or about Medicare reimbursement. You then focus your attention on rapid transportation, an entirely different method of delivering medical services. There is hardly anyone who would be more experienced in this than you. In your capacity as Dean of the Medical School, you were sensational at turning out graduates who served in rural areas. You probably have as good a record on that as any dean in this country.

I really want your judgment, philosophically, on which way you think we should go. Forgetting for the moment cost, should we close the small hospitals and transport people to the next biggest hospital, or next hospital of any kind, or should we try to keep them open?

Secretary SULLIVAN. Senator Packwood, what I really meant was that the decision should be based on local circumstances. In other words, hospitals are very unique institutions, no two hospitals are alike. Local factors include the size of population, the kinds of health services that are available in nearby communities, what is the transportation time that would be required if this particular hospital closed? But certainly I would not feel that a blanket decision to close all rural hospitals and then simply depend upon a transportation system to the nearest urban area would be a good decision. I think that approach could have some very adverse repercussions that I don't think any of us would want to live with.

The real problem that all of us face, of course, is what is the critical blend here? We do have in some instances rural hospitals that may be 20 miles apart versus another set of rural hospitals that may be 70 miles apart. In the first case, if one of those hospitals closes, I think that I would be less concerned than if it were the latter circumstance because it depends upon what are the alternatives here that are available. So it really represents, I believe, a judgment based upon what the resulting restructuring would result in and would look like that would really determine that decision.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Dr. Sullivan, I want to pursue just a moment on the matter I spoke about a moment ago on overpriced procedures. Last year, we took the best estimates that PPRC could give us, and then we cut by one-third the overpriced procedures based upon the expectation of the fee schedule.

Now the administration comes along and slashes an additional two-thirds of this remaining amount. My question is, isn't this really putting us very close to the line on overpriced procedures? And isn't this coming from the same administration which was asking us to stretch out as much as possible the implementation of the RBRVS fee schedule because we might be making mistakes, and that we needed to be cautious? And then, in addition to that, how are we going to be able to afford under the administration's proposal to increase primary care, and rural care, and inner city care in a budget neutral manner? I just don't understand that and I would appreciate your comments on it.

Secretary SULLIVAN. Yes, Senator Rockefeller.

What our proposals for fiscal year 1991 do is to eliminate a series of anomalies in our reimbursement of physicians. We have a proposal, for example, to eliminate duplicate payments to anesthesiologists. We have also incorporated into the hospital reimbursement rates payments for physicians' assistants, yet we have physicians' assistants who are directly billing there; we are proposing to eliminate this duplicate payment. And a third example is the payment for assistants at surgery.

Senator ROCKEFELLER. Mr. Secretary, you talk about some duplicates, but aren't you essentially in this budget then attempting to move procedure codes directly into the anticipated fee schedule? That is the effect of what you are doing.

Secretary SULLIVAN. Well certainly we believe that these proposed reductions in payments are appropriate. And we are in no way proposing physician payment reform, which we indeed did support because we felt that it was appropriate, it was good policy. And, as I indicated last year, I certainly support the concept that physicians should be paid well for their services because of the rigors of their training, the great degree of responsibility that we give to them, and the stress of a medical practice.

But having said all that, I don't believe that we, as a country, owe a blank check to physicians. I think there is no question that payment for services in a number of instances is excessive. And this has been shown by the development of the relative value fee schedule, where we do recognize a greater value for cognitive services: pediatricians, family physicians, et cetera. I can tell you that,

as a medical student back in the 1950's it was recognized by my colleagues in medical school and by the physicians in the hospital that the systems that we had then were totally accidental. They didn't have logic to them. That an opthomologist's services were more valuable than a pediatrician's services, or that a family physician's services were not as valuable as a urologist's services. But what we slipped into over the years was a system where we would pay for procedures because that was the easy way out; it was easy to pay for an appendectomy as opposed to taking care of a patient with cardiac shock, with a heart attack, et cetera. But there are inequities, and the physician payment reform does begin to address those inequities as well as the bonus payments for physicians.

Senator ROCKEFELLER. Mr. Secretary, I am on yellow and I have one quick question to ask.

Secretary SULLIVAN. Fine.

Senator ROCKEFELLER. I understand the flow of your response. I have no time left.

The CHAIRMAN. If you have another question, please continue, Senator.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Last year in the Energy and Commerce Committee of the House, the Health Care Financing Administration testified basically in favor of the concept that I have turned into legislation which makes Medicaid home and community-based waivers really a permanent option within the Medicaid program. Now the quote from HCFA was "We do not disagree with the intent of this bill to reduce the emphasis on institutional care and to target home and community-based services." But the administration opposed the bill based upon cost. We have since then worked fairly and fruitfully to reduce costs in that waiver bill which could shift enormously the Medicaid bias from institutional care to home and community-based care.

Can the administration, if we reduce the costs sufficiently, be supportive of this bill? Will the Secretary be supportive of this bill?

Secretary SULLIVAN. Well, Senator Rockefeller, I certainly would want to review the bill and discuss that with you.

Senator ROCKEFELLER. The concept of the bill.

Secretary SULLIVAN. As was indicated last year, I don't believe we have any difficulty with the concept of the bill with respect to the actual cost of the bill, we obviously must deal with budgetary realities. But we certainly would be very pleased to work with you on that to see if there might be a way that we could come out with something that we could support with you.

Senator ROCKEFELLER. Thank you, Mr. Secretary. I thank the chairman very much.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman.

Dr. Sullivan, you may not be the most appropriate person of whom to ask this question, but since Mr. Darman isn't here, maybe you can give me the Administration's best rationale for a concern that I have had ever since I first saw the President's. Medicare represents about 10 percent of our Federal budget, but took 14 percent of the cuts. Defense which represents about 25 percent of the budget, took 8 percent of the cuts. Now if this were 10 years ago,

and we were fighting the evil empire, I could understand that a dramatic amount of additional funding might be needed for fighting the evil empire. However, things have changed so dramatically in the last 24 months, and Eastern Europe is a much different place today than it was even a year ago.

Health care, on the other hand, as the committee's questions have indicated is really a different situation. The health care crises is more severe in South Dakota than it was a year ago. Greater and greater financial pressure is being put on hospitals and doctors, yet that isn't represented in the budget cuts. There is no sensitivity to the dramatic changes taking place in health care or to the changes in Defense. Maybe you can explain what these numbers are unable to explain.

Secretary SULLIVAN. Well, Senator Daschle, I am here as the Secretary of Health and Human Services and cannot speak for the Defense Secretary or for OMB. But let me say this, ultimately, the President makes the final call as to the budget that he sends forth.

Senator DASCHLE. Well, did he explain to you, as to why we are taking 14 percent of the cuts in Health and why Defense only takes 8 percent, even though the Defense budget is 2½ times the Health budget?

Secretary SULLIVAN. Well, no, I have not had that discussion with the President.

Senator DASCHLE. Did you ask?

Secretary SULLIVAN. No. My responsibilities were, of course, to try and develop a budget for the Department that makes sense, to try and provide essential services, but work within the limitations of the resources that are available.

On those kinds of trade-offs, I frankly don't think that I am the appropriate individual to respond. That is the President's call; he is elected to make those judgments.

Senator DASCHLE. I understand that, and I don't mean to put you on the spot because I know you have to answer to the President, but you are representing the President in the sense that these are your numbers as well as his. Frankly, if we cannot get answers from you as to why we take a greater hit in Health than we do in Defense, given the circumstances, I don't know what recourse we have to get that information. And, frankly, it, concerns me a great deal. I don't think the cuts really represent the situation in the world today; the completely different set of circumstances we had just a year ago. We need an advocate in Health in the administration. We need someone who can forcefully make just as good a case for expenditures on Medicaid and Medicare as we can for troops in Europe, or the MX missile or anything else. You know that very well. I would only say that I am very disappointed that a disproportionate share of cuts comes in the Health budget just at the time when we can least afford it, and at the time of greatest opportunity. I guess I would leave it at that.

Let me ask you, why doesn't the budget include a higher rural update? We have made some progress in the last couple of years, but there is no differentiation between rural and urban hospitals and no understanding of the importance that we need to put on an increase in the rural update this year.

Secretary SULLIVAN. Well, Senator Daschle, we did, as you know, recommend a differential update this past year for rural facilities, which was enacted. And for this year, if the circumstances suggest that that would justified again this year, we will be making such a recommendation.

Senator DASCHLE. You mean we don't know whether those circumstances justify it today?

Secretary SULLIVAN. Well, we are reviewing this, and we will be coming forward in a few weeks with that I think. It is still under review.

But let me also make one other comment concerning the budget that we have.

As you know, this budget was developed starting last spring and completed, I believe, in December. Many of the chances that you referred to that we are very heartened by—that is a reduction in tensions in Eastern Europe and Russia—really have occurred quite recently. As you know, the President has indicated in response to questions in the past that although we are very heartened by these changes, the President has exercised caution in making budgetary changes before we have sufficient time to analyze the overall situation. But the fact is that the President, in his state of the Union address, did charge me to lead a review of the health care system, to look not only at costs, but also at access to health care, and the quality of care available. I, frankly, am very optimistic and very heartened by that. It means that the President does believe that this is an important activity. He wants a careful review, and I certainly will be doing that. But until that review is completed, I cannot be more specific. Certainly we are concerned about making sure that the health care system is responsive to the needs of our citizens.

Senator DASCHLE. Well, I won't argue the point. My time is up, but I would only say that you are more optimistic than I am that another study is the answer. Secondly, I question how cautious we are when we see that 14 percent of the budget cuts are in Medicare this year, while it only comprises 10 percent of the budget. That disproportionate cut is not cautious, in my view, and it is going to have tremendous consequences in health care throughout the country. But it is something we will continue to talk about.

Thank you, Mr. Chairman, and thank you, Dr. Sullivan.

The CHAIRMAN. Dr. Sullivan, let me get back again to this rural hospital-urban hospital problem.

I am in a somewhat unique position in that my State has virtually the same number of urban hospitals as it has rural hospitals. So I guess I could be relatively even-handed in my approach. But last year in Texas we had 13 hospitals close and only three of them were urban. I certainly agree with Senator Packwood, if I read what he stated correctly. You are not going to be able to have profitable Medicare business in rural hospitals. And if you are talking about a hospital that has 25 or 30 beds, the actuarial averages just do not apply because you get surges of patients and periods where they plateau out, and you do not have the cushioning effect of a larger patient base that you have in major population centers. So I don't see how they can be anything but more expensive.

There is an urgency to the problem. I've seen my State for the last 4 years lead the country in hospitals closing. I have had more and more rural hospital administrators say we are just barely hanging on, and we are concerned that we can't hang in there for the period of time that you begin to bring these costs together between urban and rural.

I would hope very much, now with Dr. Wilensky coming aboard, that she could have as a first priority making recommendations to help us consider what to do with respect to accelerating the schedule for bringing the urban and rural rates together, what we should do about measuring the severity of illness, and where the emphasis should be. And I would strongly urge you to make that a priority, to get back to us at the earliest considered opportunity that you have.

Secretary SULLIVAN. We will be happy to do so, Mr. Chairman.

The CHAIRMAN. I must tell you one of the most disturbing things I have seen in quite a while was being at Parkland and going up to see some of the boarder babies. And I really didn't know what that term means until I went up there and found that they were talking about children that were going to be there for quite some time, that they just cannot send home. I mean they are borders at the hospital. And I saw babies no larger than my hand who weighed less than a pound. I am thinking about the life of that baby and how long it is going to last, what the results were going to be. All of us like to think of health care in this country being a right and not a privilege. And yet it looks like we are heading to some kind of a rationing of health care as we see in other countries. Unless we can do a better job of containing costs, doing what has to be done, and supporting some of these areas where obviously the cost cannot be borne by local taxpayers.

You talked about health care as being a local decision, but sometimes the economic circumstances are such that they have very little option. I know of no rural town in my State that is booming. Almost every one of them is in trouble, trying to hang in there. And I would like to see some of the people out in some of these rural areas, be able to stay on the farm and contribute and have a standard of living that is meaningful, and a big part of that is the availability of the health care.

Senator Packwood.

Senator PACKWOOD. I have no questions, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, we are very appreciative of your being here.

Secretary SULLIVAN. Thank you, Mr. Chairman.

The CHAIRMAN. And we look forward to hearing from you on these questions.

Secretary SULLIVAN. Thank you.

[Whereupon, at 10:58 a.m., the hearing was concluded.]

FISCAL YEAR 1991 BUDGET PROPOSALS

TUESDAY, MARCH 6, 1990

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m. in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Roth, Danforth, and Heinz.

[The press release announcing the hearing follows:]

[Press Release No. H-17, Mar. 5, 1990]

SENATOR BENTSEN ANNOUNCES HEARING ON REVENUE PROVISIONS IN PRESIDENT'S BUDGET AND EXPIRING PROVISIONS; REQUESTS WRITTEN COMMENTS FROM PUBLIC

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman, announced Monday that the Finance Committee will hold a hearing on the revenue provisions contained in President Bush's budget for fiscal year 1991 and all expiring tax provisions not included in the President's budget.

The hearing will be on Tuesday, March 6, 1990 at 10 a.m. in Room SD-215 of the Dirksen Senate Office Building.

The hearing will address all provisions in the President's budget affecting receipts, whether they increase or decrease revenues, with the exception of the President's proposals concerning capital gains and family savings accounts, which will be the subject of hearings to be announced later.

The President has proposed increasing Federal receipts by $21.7 billion in fiscal year 1991. That figure includes $15.7 billion in tax increases, $5.6 billion in user fees and other offsetting collections, and revenue losing provisions of $1.8 billion, which include extending or establishing tax credits for research and development, low-income housing and other purposes.

"The objective of the hearing is to provide the committee an opportunity to weigh the pros and cons of the Administration's revenue proposals. We will be considering whether the President's proposals provide real, long-term deficit reduction and whether his tax credit proposals represent an efficient use of Federal revenues. We will also debate whether the expiring tax provisions are accomplishing their intended goals and are cost-effective," Bentsen said.

The Assistant Secretary of the Treasury for Tax Policy, Kenneth Gideon, will be the only witness at the hearing.

Bentsen also requested written comments from the public on the President's revenue proposals and the expiring tax provisions not included in the President's budget.

"We want to provide the public with a full opportunity to be heard on these issues. It is important for affected individuals, groups and state and local governments to submit their views so that the committee will be presented with both sides of the coin on the President's recommendations," Bentsen said.

The President's revenue proposals are described in the following publications: *Budget of the U.S. Government, Fiscal Year 1991* (Government Printing Office) and *Summary of Revenue Provisions in the President's Fiscal Year 1991 Budget Proposal* (Joint Committee on Taxation). The expiring tax provisions are described in the following publication: *Description of Tax Provisions Expiring in 1990* (Joint Committee on Taxation). Since the Finance Committee solicited written comments on all of the

expiring tax provisions last year, interested parties need only prepare comments necessary to supplement last year's submission.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. This hearing will come to order.

No matter how you slice it, this committee is going to be charged with raising a significant amount of revenue this year. At this point, we don't know what the Finance Committee's target will be. I think it is going to be very difficult to meet Gramm-Rudman and avoid a sequester.

What we do know is that the President's revenue proposals will not get us to $13.9 billion, as his budget purports. You don't have to make a very careful examination to see that.

The Congressional Budget Office and the Joint Tax Committee have estimated the President's revenue proposals would raise only $9.4 billion in 1991. That represents a shortfall of some $4.5 billion. Based on these estimates—the ones that, incidentally, we are compelled by law to use the Finance Committee could probably raise $9.4 billion in 1991. However, we probably could not meet a revenue target of $12 billion or even $13.9 billion, as the President has proposed, without raising taxes. So, we are going to be looking to the Administration to help us come up with a realistic revenue target with a valid plan for raising enough revenue to meet that target. We will also give the Administration an opportunity to explain the differences between its revenue estimates and the estimates of CBO and the Joint Tax Committee, which are major. We have a difficult task before us. I think the most difficult task this committee has faced since I have been in the Senate.

I hope that we can work with the Administration in a bipartisan manner to meet this Nation's critical budgetary problems. With that in mind, I look forward to receiving the Administration's testimony on the revenue proposals on the budget.

I defer to my colleague, the Senator from Delaware, for any comment he has to make.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE

Senator ROTH. Thank you, Mr. Chairman.

I look forward to your testimony, Mr. Gideon, regarding the President's revenue proposal in his 1991 budget. And I am particularly interested in the President's family savings account because in many ways it is very similar to a proposal I made last year for individual retirement accounts.

I am hopeful that this year that we can reach a consensus in this area so that we can move ahead with what I consider to be one of the most critical problems of this Nation, and that is savings. So I am hopeful that in a bipartisan way that problem will indeed be addressed.

Senator Packwood, and Minority Leader Dole, and myself did introduce the President's Saving and Economic Growth Act on February 6, which, of course, includes a Family Savings Act, a capital gains tax reduction, and an IRA withdrawal proposal for first-time home purchasers.

Mr. Gideon, you are, of course, aware that there are substantial differences between the Treasury's estimates and that of the Joint Committee on Taxation. Unfortunately, according to the Joint Committee, CBO has said that they will not have their portion of the estimates done until later this week. I am hopeful that Mr. Gideon will be able to clarify for us the reason for the differences in the two estimates, and how the two estimating groups will be able to help us reach a decision on these proposals based on the revenue involved. Certainly, I commend you on your effort to raise revenue during the next year. I have seen no other proposals that make the effort to do so, and I suspect our committee will be hard pressed to raise this much revenue. And you do it while offering a number of desirable programs, including child care credits, a permanent R&D credit, energy tax credits, and a number of extensions for expiring provisions. And I look forward to your testimony.

The CHAIRMAN. Thank you, Senator.

Senator Moynihan, would you care to comment?

Senator MOYNIHAN. Thank you, Mr. Chairman. I have no statement at this time.

The CHAIRMAN. Thank you.

Senator Danforth.

Senator DANFORTH. I have no opening statement, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, if you would proceed.

STATEMENT OF HON. KENNETH W. GIDEON, ASSISTANT SECRETARY FOR TAX POLICY, U.S. DEPARTMENT OF THE TREASURY

Mr. GIDEON. Thank you, Mr. Chairman. I have quite an extensive written statement which covers the budget comprehensively, and I am here today prepared to answer questions on all of the issues that are covered in my testimony. However, in order to get right down to that point, I am going to read a very brief extract from my statement dealing primarily with one of the issues that both you and Senator Roth have raised, and that is the difference between ourselves and the Joint Committee with respect to the revenue estimates on capital gains.

As is now well known, the Office of Tax Analysis—that is our professional revenue estimating group—estimates that the President's capital gains proposal, if enacted, would raise $12.5 billion over the budget period and provide modest increases in revenue thereafter. The staff of the Joint Committee on Taxation estimates that the proposal will lose $11.4 billion over the same period and continue to lose money thereafter. Like others, I am both concerned and surprised by the $23.9 billion gap between the Office of Tax Analysis and the Joint Committee on Taxation estimates. Indeed, the disparity of these estimates contrasts sharply with the closeness of estimates made by both staffs with respect to most of the Administration's other revenue proposals.

Under the circumstances, I believe that it is essential for this committee to understand the procedures used by the Office of Tax Analysis to produce its estimates of the proposal. Accordingly, I am providing in my testimony today a detailed presentation of the assumptions, data, and methodology used to produce the Office of Tax Analysis estimates. I am sure the Joint Committee on Tax-

ation will wish to provide similar detail with respect to its estimates, including the Congressional Budget Office data on which its estimates are based.

I call on the Joint Committee on Taxation and the Congressional Budget Office to do so as promptly as possible.

This committee, and indeed the Congress and the American people are entitled to detailed disclosure of the assumptions and methodology of the estimators when the estimates vary so significantly on an issue of major importance. Because we do not now have the level of detail with respect to the Joint Committee on Taxation estimates, which we have disclosed today with respect to our own, our analysis of the factors giving rise to the difference is not complete. However, based on our current information, we have identified two major differences.

OTA's estimates imply that tax revenues from the sales of capital assets would be maximized if taxed at a 23-percent rate, that is, that is the revenue maximizing rate. It appears to OTA that the Joint Committee's analysis implies that such revenues would be maximized at a rate of around 35 percent, significantly above the current maximum average rate of 28 percent on ordinary income.

OTA analysts find it implausible that tax revenues from sales of capital assets would increase if taxed at rates higher than rates applicable to ordinary income. Stated more technically, the Joint Committee's elasticity is lower than that used by OTA and appears to be lower than the elasticity that the Joint Committee used last year, which is at a very low end of the range of existing estimates. We think it is simply too low.

The Joint Committee estimate assumes a very large increase—perhaps more than 50 percent from 1988, the last year for which we have data, to 1990—in the level of capital gains that would be recognized if there were no change in the law at all. An increase in this magnitude does not accord with historical experience and is, in our judgment, highly improbable.

These differences take on significance because we should remember that the estimators, both at the Joint Committee and at the Office of Tax Analysis, have been wrong on this issue before. Both substantially underestimated the capital gains revenues which accrued after the 1978 rate cut.

In addition, neither the OTA nor the JCT have included macroeconomic or "feedback" effects in the estimates. While this accords with standard practice of both staffs, it does not mean that such positive effects will not occur, merely that they have not been estimated.

Secretary Brady, CEA Chairman Boskin, and probably many members of this committee share the realistic expectation that positive economic effects will occur if the cost of capital is reduced through a capital gains rate cut.

As Professor Martin Feldstein recently noted in testimony before the House Budget Committee with respect to the Joint Committee estimates, "Even a microscopically small 4 one-hundredths of 1 percent" increase in the annual growth rate of GNP would produce additional tax revenues of approximately $5 billion a year. That is more than enough to offset even the Joint Committee estimate. Such growth would benefit all Americans, not just the sellers of

capital assets. Indeed, we need to provide a fiscal climate conducive to creating new jobs is what this debate ought to be about rather than an arcane dispute about revenue estimates.

Compared to the results of most studies, OTA's estimate of induced realizations, that is, how many more sales will occur is conservative. Table 1 in my testimony provides detail on these studies. And by any reasonable standard OTA has endeavored to err on the side of caution when estimating these behavioral effects.

Before analyzing the OTA estimate in some more detail, let me make one point about its source.

The revenue estimates reported in the budget were produced by the nonpolitical, professional, career, civil service staff of the Treasury's Office of Tax Analysis, which provides all Treasury revenue estimates for other legislative and budget proposals as well. It is worth stressing therefore that the difference in revenue estimates is a professional difference of opinion. Accordingly, the estimates should be evaluated on their merits, not their political appeal.

Table 2 to my testimony presents the disaggregated parts of our estimates. The most interesting line of that has typically been line 2, which deals with the induced realization effects.

As I noted before, Table 1 indicates that the elasticity estimates used by Treasury are smaller than the elasticities found in nearly all the studies. OTA assumed an elasticity of 1.2 in the short run, declining to about 0.8 in the long run. As I noted earlier, the implication of this is that the average marginal tax rate that would maximize revenues from capital gains is about 23 percent. In other words, a rate either higher or lower than that would produce less revenue than a 23-percent rate.

Now, while the implied revenue maximizing rate is a useful way to convey the concept of elasticity in a form that is somewhat more comprehensible to those of us who aren't economists, the revenue maximizing rate is not the ideal rate from the standpoint of economic efficiency and growth. Instead, it is the upper limit at which tax should be imposed. While a higher tax always imposes efficiency losses on the economy by comparison to a lower rate of tax, imposing tax at a rate above the revenue-maximizing rate not only causes efficiency loss it causes revenue loss as well.

OTA's estimates for this year do reflect a change in elasticity from the elasticity which we used last year. Last year, we used a long-term elasticity of 0.9 rather than the 0.8 we used this year. We changed that elasticity under our normal process of updating our model and in an effort to be cautious. The direction of change would have, absent changes in the JCT's elasticities, narrowed the gap between the estimates considerably.

I also want to point out that OTA has provided revenue estimates only through fiscal year 1995. Any extrapolation of the baseline beyond 1995 would either require a purely mechanical approach about estimates on economic projections or would require an independent forecast by our staff, which we do not make of such trends.

We believe it is appropriate, however, to state OTA's views as to the revenue trend expected in periods after the budget period. OTA

projects that, if enacted, the President's proposal would raise revenue modestly in all years following the 1991 budget period.

Let me move now to the issue of distribution.

The purpose of the Administration proposal is to increase incentives for savings and investment, and to increase the efficiency of capital transactions. Fulfillment of these goals will benefit all Americans. A review of Table 6 shows, however, that enactment of the proposal would not reduce the tax burden of the wealthy. Indeed, they would pay more.

Table 6 demonstrates that once the dynamic responses of taxpayers are taken into account, the amount of taxes paid by high income taxpayers will increase. Taxpayers with incomes about $200,000 will pay almost $1 billion more in taxes through the capital gains tax provision. The share of taxes paid by lower and middle income taxpayers will decline since their taxes do not increase so significantly. Thus, dynamic analysis shows that a capital gains tax cut provides a win-win situation: while high-income taxpayers would pay more in taxes, they would be better off because the capital gains tax rates will allow them to make investment decisions with less concern about the tax impact.

The Joint Committee's distributional table is based solely on the static portion of its estimate. In other words, in presenting distribution tables, the Joint Committee ignores the dynamic portion of its own estimate. The JCT table, therefore, is a distribution of the benefits of a rate cut to those who would have sold capital assets in any event, but it ignores the distribution of the additional tax paid by those who will be induced to sell at lower rates. For this reason, we think that Table 6 provides a more complete and accurate picture than the Joint Committee table.

Let me compare the estimates now.

Table 7 shows that the two main sources of the difference between the two estimates is the static revenue loss, line 1, and the assumed responsiveness of taxpayers, line 2.

We understand that the Joint Committee's baseline, which is provided to it by the CBO, is assumed to jump over 50 percent from 1988, the last year for which we have data available, to 1990. OTA believe's that the extraordinary increase in capital gains realizations projected by CBO in this 2-year period is highly improbable. Its effect is to raise the baseline level of realizations quite significantly throughout the budget window, thereby significantly enlarging the Joint Committee's estimates of the static revenue losses.

Another major difference between the OTA and JCT estimates is that the JCT estimate appears to assume a lower level of responsiveness, or elasticity, by taxpayers. And as I have noted, the only way we could replicate their elasticity was to assume a revenue maximizing rate in our model of about 35 percent.

Virtually every study in Table 1 that allows computation of a revenue maximizing rate implies that that revenue maximizing rate is below the rate imposed on ordinary income. This is hardly surprising, since just as we anticipate a portfolio effect for a rate differential in favor of capital assets—that is, that taxpayers would shift assets in order to get the favorable capital gains rate—one would also expect taxpayers to attempt to shift out of capital assets into other kinds of assets if they were taxed at a higher rate.

The considered professional judgment of Treasury analysts is that the JCT estimate is simply too low. It also seems clear that the JCT reduced its elasticity assumption from last year as well. While both the JCT analysts and the Treasury analysts regularly update and improve their models as new information becomes available, this particular revision apparently caused the Joint Committee to increase the loss it estimated for the President's proposal, and increased, rather than narrowed, the gap between the two estimates.

The revenue estimators at OTA are professionals who have labored to produce their best judgment of the revenue effect of the President's proposal. I am not an economist and I share much of the perplexity that I think members of this committee must feel with respect to how to evaluate this important disparity.

A few of my personal thoughts may be of some utility to the committee.

First, elasticity is a term that speaks mainly to economists. OTA estimators tell me that we can infer a revenue maximizing rate from these elasticities. Specifically, OTA's estimate implies that revenue would be maximized if the rate were set at 23 percent and the JCT's estimate appears to imply that we would maximize revenue if the rate were around 35 percent. Based on our historical experience with capital gains since 1978, I find it a lot more likely that we will raise revenue through a rate cut than through a rate increase above ordinary rates.

Second, I do not find it plausible that a 50-percent jump in capital gains realizations will occur in a 2-year period without a change in the tax law. Yet, that is apparently what the CBO has projected and, hence, what the JCT is required to include in its baseline estimates.

Finally, lowering the capital gains tax rate will lower the cost of capital and should promote economic growth. Even trivial increases in GNP, as noted above, will increase revenues more than amount sufficient to offset the JCT estimates. The prospect of increased economic growth emphasizes the fact that this debate should not be about technical estimating problems. It is about making this country more competitive.

Since the estimators have been unable to resolve their differences, however, Congress and the American people clearly should have all the data, assumptions, and methodology underlying the estimates which we have placed in the record today for full public scrutiny on our side.

We look forward to the disclosure of the same material with respect to the JCT estimates and the CBO projections on which it is based at the earliest possible time.

Thank you, Mr. Chairman. And I will now be happy to answer questions on all aspects of my testimony, not just the revenue estimating matters I covered in my oral statement.

[The prepared statement of Mr. Gideon appears in the appendix.]

The CHAIRMAN. Mr. Gideon, that is an interesting statement about the estimates of OTA and the Joint Tax Committee. But, I had specifically stated that we would deal with the Administration's other revenue proposals today, and that we would have separate hearings on capital gains and IRA's, which the members of

this committee are all interested in. We will look at the specific analysis by Treasury and by the Joint Tax Committee, probing into it at some length, at that time.

But at the present, as I had advised you, I want to get to the other revenue proposals.

Mr. GIDEON. Yes, sir.

The CHAIRMAN. As I stated earlier, the Congressional Budget Office has estimated that the President's revenue proposals will only raise $9.4 billion in 1991, compared to the Administration's $13.9 billion estimate.

Is the Administration prepared to give us additional revenue increasing provisions for our consideration to make up that difference? Or, are you ready to accept a smaller revenue component?

I remember last year the Treasury proposed $500 million in loophole closers to the committee. Can we expect similar assistance this year?

Mr. GIDEON. Mr. Chairman, that was pursuant to the budget agreement last year. And we were, of course, happy to come forward and fulfill our obligations under that agreement. I am not aware of any similar commitment this year. And at this point in time, I am here to defend our budget proposals.

I might note with respect to the CBO estimates, we were originally told we would not have them until tomorrow. I understand that they did come out yesterday. So I am at some disadvantage in responding specifically to exactly what those might be.

Let me say this though. It is clear that we were aware of their two significant ones. One of them is capital gains estimates which I have discussed in some detail. Another significant area of differences has to do with the IRS management initiatives that are described in our budget. As I understand it, the CBO is estimating those at zero, providing no value whatever.

Commissioner Goldberg is convinced that we can raise that revenue. He presented a concrete program to us for that purpose. We described what he is going to do in some detail in our budget document, the testimony that we have presented today, and we intend to monitor that and see that that revenue is raised.

The CHAIRMAN. Isn't it always Treasury's responsibility to try to identify loopholes for us, regardless of any prior agreement? Isn't that a basic responsibility of Treasury?

Mr. GIDEON. Mr. Chairman, we continue to look at issues of that sort. And in fact, later this month I expect to publish some studies from which this committee and the Ways and Means Committee may choose to draw inferences about loopholes that may need to be closed. Yes, that sort of thing we continue to do.

The CHAIRMAN. I would like something more than just inferences. I want you to tell us what you think should be done and can be done. Take a stand. If there are loopholes to be closed, let us analyze them.

Let me ask you about today's article in the New York Times about the big shortfall in corporate tax receipts. One of the key goals of the 1986 Tax Reform Act—and part of what sold it—was expectation that $120 billion in taxes would be shifted from individuals to corporations in the first 5 years. But what we are finding is that corporate receipts are substantially below that estimate. In-

stead of the shift to corporations, corporations are actually paying far less than was projected.

I am going to call for a hearing on March 29, to get into corporate taxes in more detail. Do you have any comment on this matter?

Mr. GIDEON. We looked at the article this morning. We believe that the primary cause is that corporate profits were not as high as were projected and, therefore, if the profits aren't there the amount of tax wouldn't be there as well.

It is worth noting, however, that in terms of a distributional shift in the percent of income tax receipts, the Tax Reform Act did accomplish that. For example, in 1985, corporate receipts were 15.5 percent of total income tax receipts, whereas, as in 1989, they were 18.9, and indeed the year before they were 19.1. So a shift in the burden did occur.

The CHAIRMAN. Well, I must state, since 1970 we have seen a very substantial reduction in the share of tax revenue coming from corporations in this country as compared to individuals and a corresponding increase in the amount coming from individuals, a very substantial one. As I compare the percentage of taxes coming from corporations in other countries with the United States, I note that it is almost three times higher in Japan, one of our principle economic competitors, that obviously is doing very well. Would you comment on that?

Mr. GIDEON. Well, I am not familiar with that particular statistic, Mr. Chairman. And obviously by the time of your hearing we will then have analyzed these things and can get back to you in more detail.

I think that one of the things that is generally agreed, however, is that the cost of capital in Japan is lower than it is in this country.

The CHAIRMAN. For quite a different reason. Obviously one of the reasons that the cost of capital is lower in Japan is because our prime rate is twice as high. Of course the cost of capital is lower there. That is part of what we are up against. That is why it is important that we be realistic in trying to bring this deficit down and not have erroneous assumptions. That is of great concern to me.

Mr. GIDEON. Well, I think that we absolutely share the commitment as a committee to bring the deficit down. I mean, there may not be consensus on many things, but I think that there is a shared consensus in terms of meeting the deficit reduction targets.

The CHAIRMAN. The problem is that, when I look at the Administration's proposals, they appear to be a mile wide and an inch deep. $3.5 billion of the revenue proposals, such as the IRS management reforms, are gimmicks, even under the President's own standards.

As I recall, when Governor Dukakis made a similar proposal in 1988, the President accused him of wanting to put an IRS man in every kitchen. I am surprised you haven't made a proposal on waste inefficiency. I guess that is what this is supposed to be. You have another $5.8 billion of recycled proposals that have been rejected by the Congress before, including the mandatory Medicare coverage for State and local workers. That proposal gives me and many members of this committee serious problems.

Do you consider those to be realistic proposals that will provide long-term deficit reduction?

Mr. GIDEON. We think that certainly those proposals, if you are talking about the IRS budget proposals, will provide a substantial increase in collections, and that increase in collections will last for several years, as shown in our budget projections.

Now, I think that those management initiatives are entirely feasible. They have nothing to do with putting a revenue agent in everybody's kitchen. What they indeed say is let's take some of the areas where we need to intensively concentrate our resources, as in the appeals area, as in the collections area, and let's move the appropriate resources into those areas and see what we can do in terms of getting the money.

I will tell you from my own experience at the Internal Revenue Service—and while this is Commissioner Goldberg's management call—I will tell you that my experience there would suggest that these initiatives should be successful, and I think that he will succeed in getting that revenue. The good part about that, Mr. Chairman, is that this committee does not have to act to do that. That is simply mining the field that is already there. I think that can be done.

As to the recycle proposal issue, I assume that is a reference to the HI issue in Social Security.

The CHAIRMAN. That is one of them.

Mr. GIDEON. That remains good policy, Mr. Chairman, and Congress ought to enact it.

The CHAIRMAN. Well, I find it very difficult to accept the idea that, without hiring any additional staff or otherwise beefing up the IRS budget, by rearranging a few desks over there—which could have been done a long time ago if that was appropriate—you are going to have any serious increase in revenue. And, of course, the Congressional Budget Office, as you stated, says it will generate nothing. Well, I have imposed myself on this committee for long enough.

Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, with all the respect that Mr. Gideon deserves and has from this committee, we have trivialized this process. We are told that we are going to somehow improve our revenue system by, we are asked, first of all, to believe that by cutting taxes on capital gains you get increased revenue, and it goes on indefinitely. We don't believe that. We know you will get it for 2 years maybe. But there we cut the capital gains we get revenue by cutting capital gains on people who actually have capital gains, which is obviously at one end of the population distribution, and then you go to payroll taxes, back to payroll taxes. You have the $2.1 billion from the OASDI, and $1.7 billion from health insurance, HI, and then $900 million from speeding up collection. You know, we once had a revenue structure that was just normal and serious and predictable.

Now we are raising revenue by saying that by fiscal year 1990, you have to put your payroll taxes in the Treasury on the next banking day after withholding. In 1991, it is the second banking day. In 1992, it is the third banking day, and in 1994, it is the first banking day.

Mr. GIDEON. Can I comment on that, Senator?

Senator MOYNIHAN. Of course you can.

Mr. GIDEON. Our proposal would say that that makes no sense. That is current law as Congress enacted it last year. We say leave it on 1 day all the way through.

Senator MOYNIHAN. Well, I know that.

Mr. GIDEON. I mean, we are straightening out a gimmick there. Granted, it is a temporary revenue effect, but on the other hand, it makes a lot more sense to leave it stable.

Senator MOYNIHAN. I know that. But that one-time effect. Let's get through to the next.

Mr. GIDEON. Well, do you think it ought to migrate over those periods of days as it would if we didn't take this action?

Senator MOYNIHAN. No, I don't. But I think you ought to come before this committee with respectable proposals.

Mr. GIDEON. I mean, we labeled that a temporary time. I mean, we said so in the budget documents.

Senator MOYNIHAN. Mr. Gideon, don't argue with me. I wasn't arguing with you.

Mr. GIDEON. All right, sir.

Senator MOYNIHAN. I mean, I am embarrassed for your situation. I expect you are too. I mean, if we are going to raise this money by cutting taxes on the rich and raising taxes on people who get paid by the hour. But payroll taxes, how much do you get from payrolls? As I understand it, you have $4.9 billion which will come from capital gains tax cut, and $4.7 billion from increase in payroll taxes. Isn't that right?

Mr. GIDEON. $2.1 billion and $1.7 billion from the two payroll provisions.

Let me comment on those.

Senator MOYNIHAN. $2.1 billion, $1.7 billion.

Mr. GIDEON. Right.

Senator MOYNIHAN. And the speedup is $900 million.

Mr. GIDEON. The speedup, yes.

Senator MOYNIHAN. Yes. There you are. If you are going to do all this, it is a combination of cutting taxes on people with capital gains. I mean, you don't have to call them rich, but they are one end of the cluster, one end of the spectrum. And a population of about two-tenths of 1 percent. And then payroll taxes. Are they attractive taxes?

Mr. GIDEON. The people in the capital gains portion are going to pay more. Let's talk about those two payroll tax provisions though. I think it is worth mentioning what they are.

The first one says that people who have no pension coverage whatsoever under the States would now be covered so that in the event that they are disabled, they would have the benefits of Social Security. In the event that they acquire no other retirement benefits, they would have the benefits of Social Security. In other words, this is one of the last groups that does not benefit from coverage in the Social Security system.

Senator MOYNIHAN. Mr. Gideon, I know that. And I would like to see those extended. But it is the pattern of taking social insurance coverage as a revenue device. It was not meant to be a revenue device. The whole pattern here is to avoid decisions. And when you

say that this administration, you know, we really want to deal with the deficit, I have to say to you, sir, objectively that if we could demistify that proposition, you don't want to deal with the deficit. The deficit is a mode of social discipline and that serves the purposes of the people downtown. And as Mr. Stockman said, it was $200 billion as far as the eye can see, and as far as we can see it is still indeed $200 billion. The CBO shows it rising slowly to about $300 billion at the end of the decade. We are told by the Comptroller General a few days ago that very shortly now interest payments will be the largest item in the budget. As a matter of fact, I think the debt service and the deficit are about equal, and that keeps mounting, and no effort is made to lower it.

How much will the debt increase in the next fiscal year, according to your plan, sir?

Mr. GIDEON. I don't have that answer, Senator.

Senator MOYNIHAN. You don't know how much the deficit——

Mr. GIDEON. I can get that answer for you.

Senator MOYNIHAN. Can I turn around and ask? Would you give me a moment? Does anybody know? Well, let's find out. Does anybody know what the debt goes up to next year? The press table; there is an opportunity to get your name in the record here. [Laughter.]

Without indicating approval or disapproval, how much, sir?

Senator Heinz. Would the estimate of too much be out of line?

Senator MOYNIHAN. Too much would be in order, I think. I hereby rule. The Senator from Pennsylvania is in order.

Sir, in all truth, you come before us, I mean not to be anything adversarial, but the thing in your mind that you are not most worried about is the debt? How much is the debt going to increase next year? Is it a hundred billion or is it 200 billion?

Mr. GIDEON. We will get back to you on that, Senator.

Senator MOYNIHAN. Does anybody know?

[No response.]

Senator MOYNIHAN. Nobody knows. Hey, wait. A table has been found. Not a moment to lose. The yellow light is on. How much will the debt go? How much will the debt go? Up, up, up, up, too much, says Mr. Heinz. Sir?

Mr. GIDEON. I don't have an answer for you.

Senator MOYNIHAN. Right. [Laughter.]

Well, there you are. It is a great moment in the history of the committee.

Senator HEINZ. Gong, gong.

Senator MOYNIHAN. The point, sir, is that if you come before this committee with revenue proposals, and have no idea how much you are increasing the debt next year, it seems to me—but you do have an idea of how to pick up $900 million by depositing payroll taxes the next day or the day after, the day before, you know, the day before you get them, or whatever like that. But that is not serious. Thank you, Mr. Chairman.

The CHAIRMAN. Let me ask. Have we given the Senator as much time as the Chairman took? All right. We will proceed in the order of arrival.

Senator DANFORTH. Senator Heinz has to leave, Mr. Chairman.

The CHAIRMAN. I would be delighted for him to go next. I would like to also state that the Senator had an opening statement which we will take for the record.

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, I thank my colleague from Missouri for a very brief interruption. I just want to put on the record that the Senator from Missouri, Senator Danforth, and the Senator from New York, Senator Moynihan, and Senators Durenberger, Symms, and Boren and I introduced S. 2025. It is legislation that combines all 12 of the expiring tax provisions and extends them permanently. The administration supports 4 of the 12 at a cost of $15 billion over 5 years, versus about $22 billion over 5 years for the entire package. And one of the reasons that we are calling for a permanent extension is that, first, we extend them every year. It is very bad public policy, as well as messy, to do it from hand to mouth. The administration does not want to extend for more than 1 year one of the programs—the low-income housing tax credit—which, insofar as I can tell, is probably the best housing program we have ever had. I hope that the administration will help us write an extender's provision, even if it is larger than what the administration has asked for. It's the certainty, and the guesswork that ties this committee up in knots in reconciliation time and time again, and forces the committee into a compromised position of that is commonly called smoke and mirrors.

The best way to avoid smoke and mirrors is to get some of the things we can and should settle behind us and make the decisions on a permanent basis.

I thank the Senator. I don't really have a question, Mr. Chairman, and I do thank Senator Danforth for letting me go ahead of him.

Senator DANFORTH. Thank you.

[The prepared statement of Senator Heinz appears in the appendix.]

The CHAIRMAN. Senator Danforth.

Senator DANFORTH. Mr. Gideon, you mentioned in your testimony that the estimators at Treasury are professionals. Is that the case? This is not a political operation in Treasury?

Mr. GIDEON. The revenue estimating staff at OTA is a completely career staff. They are not political appointees.

Senator DANFORTH. They are Civil Service?

Mr. GIDEON. They are Civil Service.

Senator DANFORTH. And they can't be sacked if they do a job that you don't approve of?

Mr. GIDEON. They certainly can't be. And they certainly tell me answers that I don't like to hear from time to time.

Senator DANFORTH. Can you go to them and say, look, this is important to the Secretary or this is important to the President. The administration's policy is that the President favors the capital gains cut, and see if you can come out with this result?

Mr. GIDEON. They try to help us structure things so that the results will score favorably under their numbers, but on the other

hand, what they don't do is change their numbers in order to meet our objectives. In other words, they tell us that if we do this or that, we can improve the revenue performance of our proposal.

Senator DANFORTH. But if you say we want to cut capital gains taxes and we want you to tell us that's going to increase revenue rather than reduce revenue.

Mr. GIDEON. They wouldn't do that.

Senator DANFORTH. They would not do that? And this is not a Republican operation. This is not some campaign team or people that are being rewarded with work in the Department?

Mr. GIDEON. It is not.

Senator DANFORTH. You inherited them.

Mr. GIDEON. I inherited it.

Senator DANFORTH. And if in the next election, say Senator Bentsen were elected President, his administration would inherit the same people.

Mr. GIDEON. And his Assistant Secretary would have to deal with the same folks.

Senator DANFORTH. So if he were to say, what would be the tax consequences of reducing the capital gains tax, they would say it would increase revenue.

Mr. GIDEON. Certainly, if he presented in the same proposal that we just presented.

Senator DANFORTH. I would like to underscore what Senator Heinz said, particularly about the low-income housing tax credit, and hope that the administration can find a way to support making it permanent.

The last decade was a disastrous decade for low-income housing. The 1986 tax legislation, whether you like it or don't like it, as a general principle really was bad for housing. And the one thing that we did in the 1986 Act to offset the general effect of the legislation on housing was to create the low-income housing tax credit. And all of the evidence indicates that it has been very effective. I know in my State it has been very, very effective, 99.85 percent utilization last year. And I simply want to underscore the comments of Senator Heinz. Senator Mitchell has introduced a bill that specifically deals with the low-income housing tax credit and making it permanent. There are 74 co-sponsors including the author, of that legislation. And it is very hard to get 74 people in the Senate to agree on anything yet they agree on making the low-income housing tax credit permanent.

The President took the position in a speech in Dallas that he wanted a 3-year extension. Now, the administration has changed its mind and moved to 1 year. And my hope would be that the administration would revisit it in an attempt to work with us and make the credit permanent.

Mr. GIDEON. I think that we will be happy to work with you on that issue. I think that as you will note in terms of last year, we had serious reservations about the credit. And it was not in the budget. This year, it is in the budget, albeit for a 1-year period. I think that as our confidence with it grows, it is an issue that obviously can be discussed.

Senator DANFORTH. Clearly, the administration has recognized this with respect to the R&D credit. If we can make these provi-

sions in the tax code permanent, it is much easier for people to make their plans than if they are existing for just 1 year at a time.

Mr. GIDEON. Well, I think that is correct. And it is particularly important with regard to the R&D credit, where the on/off switch may be affecting the level of R&D.

With the low-income housing credit, as you noted, in most States we already had close to full utilization. For that reason, we thought we could take another year look at it in terms of how it was working before making a final decision.

Senator DANFORTH. But it appears to be working well. And I think that there are a lot of us who feel that we really should be doing a better job on low-income housing and that this is one way that we could do it.

Mr. GIDEON. Well, Senator Danforth, I want to underline that we are here to support extension of the low-income housing credits for a year. In other words, that basically I think is a positive development with respect to the credit.

Senator DANFORTH. An animalistic approach by the administration, where the President originally told us he wanted 3 years, and we took that as administration policy. And in my own view, the administration has reneged on that by now shifting down to 1 year. And again, repeating myself and underscoring the comments of Senator Heinz, I would rather make it permanent.

Mr. Gideon, let me preface this question by saying that, clearly, if taxes are due and they are not paid, the Treasury and the American people are being ripped off. Much has been written over the years about underground economies. Much has been written about cash economies, cash payments, and the possibilities of avoiding the payment of taxes by dealing in cash.

Jim Beggs presented to me some months ago what he called the fair share transaction audit system, and I think that he has briefed the administration on this proposal. Do you know what I am talking about?

Mr. GIDEON. I had one meeting with Mr. Beggs' group and that was a preliminary presentation. But, yes, I am aware.

Senator DANFORTH. My understanding of it is that the technology is available to provide those who deal with businesses on a cash basis with some kind of a receipt which is automatically recorded and it can be audited by the IRS. So that it is a very simple way for the IRS to find out how much in the way of cash transactions have occurred. And I would think that this would be one thing that would be at least worth very careful attention by the administration. It is simply a question of compliance. It is not a question of raising taxes on anybody. But the view of Mr. Beggs is that it would produce a very, very large amount of revenue.

Mr. GIDEON. We are always interested in new compliance ideas. And I think Mr. Beggs has met at this point with the Internal Revenue Service. We would, of course, defer to their superior expertise in terms of dealing with issues like this in terms of evaluating it. But I would say that we welcome ideas that have a genuine opportunity to increase compliance. And if the results on this are that the IRS think it is a good idea, I think you could expect us to come back and tell you that.

Senator DANFORTH. Could you raise the question with the IRS, open the issue? Obviously it would make matters easier for us if Treasury had a specific proposal on compliance. And if you could go back and raise the question with IRS and let us know what you think about it, I, for one, would appreciate it.

Mr. GIDEON. I will be happy to do that. I would note that in the budget, in addition to the management initiatives, there is new money for the Internal Revenue Service as well. And there is no disagreement between CBO and the administration that expanding more resources at the IRS——

Senator DANFORTH. Right. But I am not talking about the point that Senator Bentsen made about the IRS guy in your closet and so on. This is simply a mechanical thing that keeps track of cash transactions on an automatic basis. So it would seem to me to be unintrusive hut very effective if it works. I don't know. It struck me when he told me about it that it was worth pursuing.

Mr. GIDEON. I think that was the real question, Senator. And I think that we look forward to further evaluation of it.

Senator DANFORTH. Thank you.

The CHAIRMAN. Senator, we will have another round of questioning and one after that, if the members so desire.

Let me ask you specifically, Mr. Gideon, about why the administration did not propose extending many of the expiring provisions. These include the exclusion for employer-provided educational assistance, the targeted jobs credit, which I worked on several years ago, and others on the committee have taken on and devoted a great deal of time to, the exclusion for group legal services, the business energy credits, and mortgage revenue bonds. Why didn't the administration include them?

Mr. GIDEON. Well, as you have already noted, Senator, we operate in an era of serious revenue constraints. All of the expiring provisions are ones which the Congress has time after time chosen not to make them permanent. That indicates at least some degree of reservation, I think, up here, as to whether they should be permanent provisions in the code.

The CHAIRMAN. But when it came down to a decision, we did extend them. But you have chosen not to even do that.

Mr. GIDEON. That is correct with respect to some of the provisions that you have mentioned. Part of that is a revenue concern, part of it in the case of several of those provisions is concern about the program. And the targeted jobs tax credit is one in which we have had severe doubts as to whether that really was increasing employment as opposed to simply giving a credit to folks who would hire people in these classes anyway. That seems to us to be a serious issue about the job inducing portion of that particular credit. I think that we have had reservations about the efficacy of some of the tax exempt bond programs.

Our attempt was simply to say, okay. With respect to three of these, we think they are good policy, we think they work. Let's make them a permanent part of the code. Let's put that revenue cost in there.

With respect to the fourth, we have had reservations in terms of its economic effect. On the other hand, Secretary Kemp is a great

proponent of the low-income housing credit, and we said let's extend that one another year and see how it works.

And then as to the others, we made the hard choice and said, all right, let's don't extend these. If we have erred in that judgment, obviously we will be corrected in this process up here. But it was an attempt to get off the cycle of perpetual reauthorizations that I think has been complained of properly.

It may be that the Congress will choose to reauthorize all of these. If it does, it will be necessary obviously to pay for them.

The CHAIRMAN. Mr. Secretary, I continue to be not just amused but somewhat astounded by the perception that this administration is not in favor of increasing taxes. And yet, the administration has proposed raising the airline passenger excise tax from 8 percent to 10 percent and raising the taxes on airline fuels. Don't you consider that a tax increase?

Mr. GIDEON. We think it meets our definition of a user fee because those are dedicated revenues that will be used to increase the air transport system.

The CHAIRMAN. But then tell me, how do you feel about a gasoline tax? Wouldn't that qualify as a user fee under your definition? Or, how about a tax on all farmers to pay the Agriculture Department's budget. It seems to me that the administration bends its interpretation to suit its objective.

Mr. GIDEON. I think we have tried to be consistent with our principles, Mr. Chairman. I think at the same time we recognize the need to finance some of these important activities.

The CHAIRMAN. All right. How about the gasoline tax. How do you feel about that? Is it a tax or a user fee?

Mr. GIDEON. We think that a substantial increase in the gasoline tax raises real problems. We think that is a tax. We have concerns about its disproportionate impact in some States——

The CHAIRMAN. That is a tax. But if it is imposed on airlines or passengers on airlines, then it is a user fee. That is interesting. That really is. They can look at definitions again.

Let's talk about the administration's proposed energy exploration tax incentives. In January imports accounted for 54 percent of domestic oil consumption. That is one of the highest levels ever, and it has had an enormous impact on our trade deficit. In that light, the administration's proposals seem inadequate to me. In 1987, I proposed legislation providing that, if we passed 50-percent dependence on foreign oil, the President should take such steps, or recommend such legislation as necessary to reduce that dependence. A lot of people jumped to a conclusion that that meant an oil import fee. That is not necessarily so. It can mean conservation. And I note here that the administration has proposed eliminating tax alternative sources of energy.

Shouldn't the administration be supporting legislation that would curtail dependence on imported oil in excess of 50 percent, by whatever means?

Mr. GIDEON. Well, we have proposals in the budget, modest I admit they are.

The CHAIRMAN. They sure are.

Mr. GIDEON. But the point is that they are a beginning. We have not thus far succeeded in persuading the Congress to go with us even that far. We think that that is a good place to start.

The CHAIRMAN. Well, I am glad you agree they are modest, because I think they are really quite inadequate. It seems to me that we are heading for what could be a serious crisis in this country by the middle of this decade if there is a continued increase in the dependence on foreign oil. That would also increase our trade deficit. We shouldn't wait for the crisis. We should be trying to prevent one.

I notice the administration is proposing to increase existing fees on securities market transactions, extending them to cover over-the-counter transactions. The expressed intent, I understand, is to pay the cost of the Securities and Exchange Commission, making it a self-funded agency. But, I understand that the current receipts from existing SEC transaction fees exceed the SEC's budget. Now you are proposing to increase the fees to raise about $80 million this year. Doesn't that make it a tax and not simply a fee, if you raise more than the budget of the SEC? Would you comment on that, please?

Mr. GIDEON. We believe that those fees are appropriate in that area. I am not aware of the precise relationship between the SEC budget that you described, but I would be happy to get back to you on that.

The CHAIRMAN. All right.

[The information appears in the appendix.]

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, I am able to report that most elusive and evidently inconsequential number that we were talking about before you arrived. And, Mr. Secretary I can report to you, if you look at page 98 on our blue book you will find that the Federal funds deficit for 1991 is $216 billion, the same $200 billion Mr. Stockman said you can see as far as the eye can see.

You pick up a little money on coins and things like that, so it actually ends up at $206 billion.

Now, sir, in all truth, I mean to come before this committee and talk about these cats and dogs and moving the day in, and pay your deposit, your payroll taxes the day before you get them, on the afternoon, in the morning, or whatever, and pick up at night, and not to know that the President is proposing to increase the debt by yet another $200 billion is to make one ask, in all truth, what perspective are you dealing from?

Very shortly now the debt service will be the largest item in the budget, larger than debt transfers and larger than Defense, larger than Social Security.

By definition, a debt service goes to people who own Treasury bonds and institutions. And again, one is making some generalizations. But it is on the far end. It is on the spectrum of wealth, possession of wealth as against income. It is very much concentrated. It now takes half the personal income tax to pay the service on the debt. Isn't that right? Right or wrong?

Mr. GIDEON. That would be pretty close.

Senator MOYNIHAN. Yes.

Has there ever been as much a transfer of wealth from labor to capital in our history? And no change in it coming. I thought we were over that fever of the 1980's, the kind of concerns that would be normal to a country like Canada or Holland or other countries would be normal to us. You don't have that kind of extraordinary transfer. You don't let your taxation system become regressive. You know when you are adding to the debt. You know when you are not. We have not done anything about the deficit.

Mr. GIDEON. Well, the interest, of course, on the debt is taxable. So we are going to tax everything.

Senator MOYNIHAN. Oh, thank you very much, Mr. Gideon. I didn't know that. You learn something all the time around here. It is $200 billion. The debt goes up $200 billion. I think the debt service is about $180 billion. And yet when we talk about employer-paid benefits, for educational benefits, that is not here. Now, employees takes some money who is working and going to school nights and learning something useful and add to his productivity. We don't want that. We cannot afford that. We can afford to add another $200 billion to the deficit, which will add another $20 billion to the debt service next year. Does that make any sense?

Mr. GIDEON. Well, Senator Moynihan, we have presented a budget which meets the Gramm-Rudman deficit reduction target.

Senator MOYNIHAN. Well, yes, sir. I mean, that is the agreed target.

Mr. GIDEON. That is the agreed target and we are meeting it.

Senator MOYNIHAN. But do you consider that the deficit under Gramm-Rudman is the real deficit?

Mr. GIDEON. I think that as you will note in the budget presentation, as I am sure has been discussed in more detail with the Budget Director, we have proposals to go beyond the Gramm-Rudman deficit as well. I mean, we understand that the job is not finished at that point. But that was the agreed on path to reduce the deficit and we are on target.

Senator MOYNIHAN. I know you have to say that. I don't blame you for doing it. But it is a profound deception that we are involved with here, a profound deception.

What if we said you are going to have the debt ceiling go up this year. Right?

Mr. GIDEON. Later in the year probably.

Senator MOYNIHAN. No, not probably, sir. Right. What do you say that we only let it go up by the amount of the deficit under Gramm-Rudman.

Mr. GIDEON. My guess is that wouldn't work.

Senator MOYNIHAN. My guess is the Federal Government would go bankrupt. Right?

Mr. GIDEON. We would default.

Senator MOYNIHAN. You would default, yes. Well, why not. Why don't you get it out in the open?

Mr. GIDEON. A default?

Senator MOYNIHAN. Yes. I mean, is default better than deception? I mean, are we telling ourselves we have a deficit of what, $32 billion, when in fact it is $206 billion, that same that Mr. Stockman to his credit got it straight, $200 billion as far as the eye can see. And I think the Japanese know that since they lend it to

us. But our own people do not. I mean, it is something unseemly, I don't mean to seem accusatory. I don't mean that. I really don't mean that. But, Mr. Chairman, it is unseemly for us to be sitting around transferring payroll taxes to the banks electronically in the afternoon to pick up $50 million or something and not say we have a deficit of $206 billion. And to say that we will have fuels for airlines user fee, but for automobiles, oh, no.

The Chairman just said something so profound. You know, we are now past the 50-percent point on imported oil as a percentage of our use. There is not much oil left in the lower 48. And I don't ask the Chairman to associate himself with this, but any responsible government would put a 30-percent tax on gasoline immediately. But you won't.

Mr. GIDEON. Other folks who live in other places might find that very unacceptable, Senator.

Senator MOYNIHAN. Yes. I know. I know. So the debt goes up, and the debt goes up, and the debt goes up. You have turned us into a debtor nation. In the 1980's, we borrowed as much money as we borrowed during the Second World War, tripled the debt. When does the debt past $3 trillion? Do you have a date on that? It will happen on your watch, sir.

Mr. GIDEON. I don't have a date on that, Senator.

Senator MOYNIHAN. Does anybody have a date? You know, is it next July 12? Hey, wait. We have a press table response. We have finally found a research resource. When will it be?

A LADY FROM THE AUDIENCE. It already is.

Senator MOYNIHAN. Oh, it has passed $3 trillion already?

A LADY FROM THE AUDIENCE. Yes, sir.

Senator MOYNIHAN. Oh, gosh. I am sorry. When is it going to be 4? [Laughter.]

Mr. GIDEON. I don't have the answer to that, Senator Moynihan. Usually my role is tax policy. The debt has not come under my area.

Senator MOYNIHAN. At $200 billion a year times 5 equals 1, so I would say 1995 it will be $4 trillion if the Japanese lend it to us. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Danforth.

Senator DANFORTH. Mr. Gideon, what is your title?

Mr. GIDEON. I am the Assistant Secretary for Tax Policy.

Senator DANFORTH. Does the Assistant Secretary of Tax Policy operate out of the Treasury Department or out of OMB or where?

Mr. GIDEON. Out of the Treasury Department.

Senator DANFORTH. You are not the budget person, are you in the administration?

Mr. GIDEON. No, I am not.

Senator DANFORTH. You are a tax lawyer, and your job and the job of your staff is to attempt to put together legislation, to analyze legislative proposals relating to taxation, but you are not one of the budget negotiators, are you?

Mr. GIDEON. That is correct.

Senator DANFORTH. My understanding is that the budget negotiations take place between the administration and Congress.

Mr. GIDEON. That is my understanding as well.

Senator DANFORTH. The administration does not do it all by itself. In fact, every time at the beginning of the year the President sends the budget to Congress, the automatic response by one and all is this budget is dead on arrival. Isn't that right?

Mr. GIDEON. Well, hopefully, that is not always the response, although it seems to be a chorus for many.

Senator DANFORTH. It has been the response ever since I have been here. Whoever the President, it has always been said that the budget is dead on arrival. And it is something that has been negotiated between the Senate, but subsequently negotiated between whatever the administration is and whoever the leadership of Congress is. And they all go back in a back room, and spend weeks and months putting together figures, and then they come out with a proposal. So it is hardly the case that you, Ken Gideon, are the spend galley behind the Federal debt. Isn't that true?

Mr. GIDEON. Well, I certainly hope not.

Senator DANFORTH. All right. Thank you.

The CHAIRMAN. Mr. Secretary, I note that once again you are proposing to impose the Medicare tax on all State and local employees. In my own State, about a half a million Texans would be affected. I think Senator Moynihan is to be commended for pointing out that middle-income Americans are picking up more and more of the tab; less and less is being picked up by higher income Americans. But, you come up here again talking about subjecting more people to the HI tax. That idea has been before us time and time again. It has been rejected by the Congress. A lot of States are affected. It is not just my State. California, Colorado, Illinois, Louisiana, Maine, Massachusetts, and Ohio are also affected. That is for starters.

What is the income level of the people that you are targeting? And we are talking about applying this tax in States that already have hospitalization insurance plans duplicating existing coverage?

Tell me the income level of the people that would be affected.

Mr. GIDEON. It would be all of the people who are subject to the current Social Security wage cap, which I think is in the fifties right now. I will have to give you the exact number as to where the wage cap cuts off now.

The CHAIRMAN. What would be the maximum.

Mr. GIDEON. That is the maximum.

The CHAIRMAN. I think it is about $51,000 or so now. I was $300 off. It is $51,300. That is the group you are talking about; that is the recommendation we are getting. I think you are going to have considerable opposition to that one; I know of one Senator in particular.

Mr. Secretary, we are a long way apart. I hope you will take affirmative action in proposing alternatives to revenue measures that have been repeatedly rejected by this committee and by the Congress. Let's see if we can work together in a bipartisan way to try to come a lot closer than we have thus far in meeting the Gramm-Rudman target.

Do you have any further comments, Senator Danforth?

Senator DANFORTH. I don't, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, thank you for your appearance.
Mr. GIDEON. Thank you very much, Mr. Chairman.
[Whereupon, at 11:26 a.m., the hearing was concluded.]

FISCAL YEAR 1991 BUDGET PROPOSALS

THURSDAY, MARCH 22, 1990

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Bradley, Rockefeller, Packwood, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-20, Mar. 8, 1990]

SENATOR BENTSEN ANNOUNCES HEARING ON 1991 BUDGET PROPOSALS; COMMITTEE TO EXAMINE PRESIDENT'S PROPOSED SPENDING CUTS, POLICY INITIATIVES

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman, announced Thursday that the Finance Committee will hold a second hearing on proposals for spending cuts and proposed changes contained in President Bush's budget for fiscal year 1991.

The hearing will be on Thursday, March 22, 1990 at 10 a.m. in Room SD–215 of the Dirksen Senate Office Building.

"This hearing will provide the opportunity for interested individuals and organizations to comment on proposed cuts in health income security and social service programs contained in President Bush's 1991 budget. In particular, the hearing will focus on recommended budget cuts and policy initiatives in the Medicare, Medicaid, Foster Care, Child Support, Supplemental Security Income, Aid to Families with Dependent Children and other programs under the Committee's jurisdiction," Bentsen said.

"Representatives of the Physician Payment Reform Commission and the Prospective Payment Commission will be among those commenting, and I'm sure the Finance Committee members will find their views helpful," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS

The CHAIRMAN. This hearing will come to order. Today we are having a hearing on some of the spending cuts and policy changes that have been proposed by the Administration in the 1991 Budget, pertaining to Medicare, Medicaid, foster care, and other income security and social service programs that come under the jurisdiction of this committee.

The Congressional Budget Office estimates that the Administration's budget proposals would lower the payments for services under the Medicare program by some $5.2 billion. Now that is the largest single spending reduction proposed in the President's budget. And of the total of $3.9 billion, 75 percent would be brought about by reducing payments to hospitals for both inpatient and outpatient services. About $990 million, or 19 percent, of the

cuts would come from payments to physicians. In my view the size of those proposed cuts are excessive.

Hospitals would be the principal source of the savings. Yet I am told that half of the hospitals in the country are losing money on Medicare. In my own State of Texas it is estimated that 70 percent of them are losing money on Medicare and the situation is deteriorating. Some of the proposals, such as reducing the indirect medical education adjustment from 7.7 percent to 4.05 percent, have been rejected previously by this committee.

With regard to physicians' payments, the Physician Payment Review Commission suggests that many of the Administration's proposals would interfere with the implementation of the payment reform package that we just enacted. Now while I do not believe that this committee can accept the Administration's proposed $5.2 billion cut in Medicare, we undoubtedly are going to have to take some steps to reduce the growth in Medicare expenditures which increased by 35 percent between 1985 and 1989. That is more than twice the increase in the Consumer Price Index.

We have a superb panel of witnesses this morning and I am going to ask them to give us some guidance about these proposals which will help us make the necessary Medicare cuts in a way that is least disruptive to good patient care. We will also be looking for guidance on the issue of Federal funding for foster care placement and the Administrative activities under Title 4(E) program.

Ms. Janice Gruendel, Deputy Commission, Connecticut Department of Children and Youth Services, will present the views of the American Public Welfare Association on the Administration's proposal to impose a 10-percent limit on annual increases in Federal matching for costs incurred by the States for foster care placement and administration.

In addition to those witnesses who requested the opportunity to appear today, we will be hearing from the two Commissions that are charged with advising us on Medicare policy. Dr. Phil Lee, the Chairman of Physician Payment Review Commission, agreed to join us today. And although the PPRC annual report is not due until April 1, Dr. Lee is here to discuss the Commission's reaction to the proposals in the President's Budget affecting payment to physicians. Dr. Bruce Vladeck, President of the United Hospital Fund of New York and a member of the Prospective Payment Assessment Commission, will report to us on PROPAC's annual recommendations for change in the Medicare prospective payment system for hospitals.

I am sure today's hearings will be helpful to the committee—they had better be—[Laughter.]

The CHAIRMAN [continuing]. As we prepare our 1991 Budget. It is not going to be an easy task.

[The prepared statement of Senator Bentsen appears in the appendix.]

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. No questions, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. No questions, Mr. Chairman.

The CHAIRMAN. May we have our first panel—Dr. Lee and Dr. Vladeck. Gentlemen, we are pleased to have you. Dr. Lee, would you lead off with your statement, please.

STATEMENT OF PHILIP R. LEE, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION AND DIRECTOR, INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, SAN FRANCISCO, CA, ACCOMPANIED BY PAUL GINSBERG, EXECUTIVE DIRECTOR

Dr. LEE. Thank you, Mr. Chairman.

I am pleased to be here on behalf of the Physician Payment Review Commission to discuss the President's proposals to slow the rate of increase in Medicare expenditures for physician services. I am accompanied by Dr. Paul Ginsburg, on my left, who is the executive director of the commission.

At the outset, Mr. Chairman, let me commend this committee for the central and really outstanding role that it played in shaping the Medicare reforms for physician payment enacted last December. You not only put the Medicare program on a sound course for the future, but you have demonstrated to the private sector that constructive reforms are not only possible, but they can have broad based support.

In my statement submitted for the record I deal with three areas. First, comments on the overall direction of the Administration's proposals, focusing particularly on its relationship to implementation of the major reforms enacted last year. Second, review of specific reductions in physician payments that have been proposed. And third, comments on the cost estimating assumptions used by the Medicare Actuary and the CBO concerning the response by physicians to fee changes.

First, let me say a few words about the overall proposal. The proposals come shortly after passage of the major reforms in physician payment under Medicare, reforms that were developed by Congress over a number of years and after very careful and very thorough analysis. Care must be taken to avoid short-term budgetary policies that are inconsistent with the policy decisions underlying the reform.

The commission is particularly concerned that legislating sharp reductions in payment rates to take effect while we were in the process of implementing the major reforms could make achievement of the reforms more difficult. Increasing the speed and magnitude of reductions in fees for services slated to be paid less under the Medicare fee schedule would exacerbate the disruption to physicians and risk limiting access to beneficiaries.

Substantial reductions in the Medicare Part B budget would limit funds available for the payment increases for evaluation and management services and for care delivered in rural areas due as part of the reform. Medicare payment rates for many physician services will change substantially over the next few years. The OBRA–89 reductions in prevailing charges for overvalued procedures will take effect next month. Then, on January 1, 1992, the first phase of the Medicare Fee Schedule will be implemented. Between these two steps, the commission estimates that 69 percent of

the payment changes projected under the full implementation of the fee schedule will have been made. That is a very big step by 1992.

For many overvalued procedures delivered in localities with high charges—for example, in New York, Miami and Los Angeles—the cumulative reductions in payment from this point to 1992 will total 23 percent. For some physicians the limits on balance billing will reduce their revenue for these services by an ever larger percentage. The Administration's proposals would increase these reductions substantially.

We are also concerned with the impact of the Administration's proposals on the private sector and State Medicaid programs. By beginning the implementation of the fee schedule in 1992 and stretching the transition to 1996 the Congress provided time for other payors to decide to follow Medicare's lead and to implement changes before the Medicare changes are complete.

If the transition were accelerated, as is called for by the Administration's proposals, this opportunity for limiting payment differentials and for the private sector to adopt the reforms would be seriously compromised.

Let me say a word about the specific budget proposals. If reductions are needed, we think that reductions of the MEI update for 1991, except for primary care services, is a suitable option. While we support the reductions in overvalued procedures over time, we are concerned that the absence of new data from Dr. Hsiao makes the proposals risky. We would urge that this committee press the Health Care Financing Administration to ask Dr. Hsiao to submit the results of his studies at the earliest possible time.

If reductions are needed, we think that the proposed reductions of anesthesiology and radiology are in the right direction, but we are concerned that the reductions proposed are too large. While we support the objectives of several of the other proposals, including reduced payments in overvalued localities and payments to assistants at surgery, we do not support the Administration's proposals. Our analysis of these and other Administration proposals are detailed in my testimony.

Assumptions behind the estimates of savings a very important issue for the committee. We have serious concerns about the assumptions used by both the Medicare Actuary and the CBO in estimating savings from payment reductions. We believe they have overestimated the volume response to the payment reductions. The result is that bigger reductions are proposed in the fees than we think are necessary to achieve a savings target.

Let me conclude, Mr. Chairman, that while the need to reduce spending continues, sharp reductions in Medicare payments for physician services, beyond those already mandated by Congress, carry some risk. Large reductions that coincide with the implementation of the payment reform would jeopardize some of what Congress has already accomplished in last year's legislation.

I hope that the commission's analysis of the specific proposals from the Administration will help the committee, both in its assessment of overall budget reduction targets and its development of specific policy options once the target has been set. The Commission stands ready to assist this committee in any way that we can.

Thank you.

[The prepared statement of Dr. Lee appears in the appendix.]

The CHAIRMAN. Thank you.

Dr. Vladeck?

STATEMENT OF BRUCE C. VLADECK, PH.D., MEMBER, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, NEW YORK, NY, ACCOMPANIED BY DR. DONALD A. YOUNG, EXECUTIVE DIRECTOR

Dr. VLADECK. Thank you, Mr. Chairman.

It is a pleasure for me to be here this morning to represent the commission. I am accompanied by—and it is also a pleasure to be accompanied by Donald Young, M.D., the executive director.

Earlier this month we submitted our 6th annual report to the Secretary and to the Congress. You have received copies. We have had written testimony that you have had a chance to see, I hope. I will try to be very brief, therefore, in summarizing.

Two sets of points. First, some observations on what is happening to hospitals under PPS and then some of our specific recommendations. I think the bottom line is that since the inception of PPS in fiscal year 1984 the rate of increase in Medicare's expenditures for inpatient hospital care has clearly moderated. Much of that is attributable to reductions in volume. But even on a per case basis, Medicare expenses for inpatient hospital service have grown less quickly than they had in the past.

I think it is also true that for the first 4 years of the PPS system, hospitals had quite a favorable experience in terms of positive margins. But more recently, as you noted in your opening remarks, Mr. Chairman, that situation has begun to turn around.

In our analysis the shrinkage of PPS margins and the projections for still further movement into the negative range this fiscal year and next is attributable largely to rates of cost increase on a per case basis—2 to 4 percent higher than the measures of inflation that we use in the system, not to the rate at which payments are increasing payments because of case mix change, continue to grow at a rate faster than the market basket rare of increase.

Our latest estimate suggests that sometime in 1989 the average hospital under the PPS system began to experience a negative margin and that situation has probably gotten worse since then.

We are particularly concerned, as you know, about the variability of margins. Some hospitals continue to do very well; some do more poorly. We believe that has to do with some aspects of the payment system that continue to need investigation and review and probably some reform.

With that as background, let me quickly summarize our principal recommendations for fiscal year 1991 and very briefly contrast them with those of the Administration. We are recommending an average update of 4.9 percent as opposed to 4.1 percent in the President's Budget. Our recommendation averages to an increase of half a percentage point less than the projected market basket which is what is called for in current law, and thus a savings of roughly $250 million relative to current law.

Within that overall update, we are recommending different updates for urban and rural hospitals—7 percent for rural hospitals;

and 4.5 percent for urban hospitals. We have an established methodology we use each year to arrive at our update recommendations. It is summarized in the written testimony, but let me just quickly review the major components.

We project hospital price inflation for the fiscal year 1991 at roughly 5.4 percent. That is the market basket. We believe that increase in costs associated with scientific and technological development can be funded from increases in productivity, which we are required to consider under our statutory obligation. We believe that central to hospital payment and the growth in Medicare expenditures under the PPS system has been the growth in case mix, reported case mix has actually produced more revenue than the update factors. We are projecting about 2.5 percent increase in payments due to reported case mix for fiscal year 1991. And we believe in fiscal year 1990 that at least 0.5 percent of the increase reported case mix resulted from improvement in medical records, rather from real changes in patient characteristics. We believe this 0.5 percent should be removed from the payment base. So that is how we come to 4.9 percent. On average, given hospital margins and given what we know about costs, we believe this is a reasonably tough recommendation.

We also have recommended that there be different updates for rural hospitals as opposed to urban. We share the concern, which this committee has been in the leadership role for such a long time, about what has happened to many of our rural hospitals under the Medicare PPS program, and are proposing a phasing out of the differential between the standardized amounts for rural and urban hospitals over 3 years with one-third of that taking place in fiscal year 1991 in a budget neutral fashion. That produces the difference in the urban and rural updates.

Now we are also recommending an increase of 5.6 percent, for the excluded hospitals, the psychiatric, rehab, and children's hospitals excluded from PPS.

And let me just quickly comment on two other issues on which we spent a lot of time. We have probably spent more time on the indirect medical education adjustment than any other issue that has been before us in the last couple of years. As you know, the current formula provides for a payment increase of 7.7 percent for every 0.1 percent increase in the ratio of interns and residents to beds. Our empirical estimates suggest that that number may be overgenerous. Our empirical estimates suggest that from a technical point of view that number ought to be closer to 3.2 percent.

On the other hand, we are very concerned about the teaching hospitals. Our data show that under PPS alone they do better than any other class of hospitals in the system. But overall, all sources of payments, revenues from all payors, they do worse than any other class of hospitals.

The CHAIRMAN. What was the last part? What did you say that was?

Dr. VLADECK. Under Medicare, the teaching hospitals do better than any other group of hospitals. Under all sources of revenue as real total entities, they are doing worse than any other class of hospitals.

We do not fully understand that. But clearly, a lot of that is attributable to their role in the provision of care to the medically indigent and in their dependence on the Medicare program as states have cut back hospital payments under Medicaid. We are continuing to look at that. But it is clear that a substantial reduction in Medicare indirect medical education payments would have a very adverse effect on teaching hospitals which are already very close to the margin in terms of their overall economics. Many of these hospitals play a central role in the provision of uncompensated care in many communities as well as their other very important contributions to the system and to society.

One quick last point. We have looked very carefully at the issue of access to care in rural areas relative to our recommendations on the standardized amounts and others. And we recently had the benefit of a study we commissioned which seemed to suggest that at least as late as 1986 Medicare beneficiaries in rural areas were continuing to use Part A hospital services at a rate at least as high as Medicare beneficiaries in urban areas. Their use had fallen since PPS but so have urban beneficiaries.

But there is an increasing tendency on the part of rural Medicare beneficiaries to receive specialty services in urban hospitals. And much of what we are seeing in the rural hospitals may be a result of that trend. We are continuing to watch this issue, continuing to look at it. We know of many individual cases where the financial distress of rural hospitals has caused access problems. But in the aggregate, there has not been substantial damage to the access to care on the part of rural Medicare beneficiaries.

Obviously, we are happy to answer any questions about this or any other part of our report or testimony. We are very grateful for the opportunity to be here. I thank you, Mr. Chairman.

[The prepared statement of Dr. Vladeck appears in the appendix.]

The CHAIRMAN. Thank you, Doctor. For one from the Nation's largest city to speak as you have on rural hospitals is certainly of interest to me.

Dr. Lee, you know, this committee is charged with a responsibility of trying to reach the targets under Gramm-Rudman. As I stated earlier, physicians will probably have to make a contribution to that effort. I know that you have expressed concern about the effects that several of the Administration's budget proposals might have on the transition to the new payment system for physicians.

Of the Administration's approximately $990 million in proposed savings from physicians services, the Commission appears to urge outright rejection of items that CBO estimates would save approximately $285 million, and OMB estimates would save approximately $320 million in fiscal year 1991. In addition, you suggest that many of the remaining proposals ought to be modified in ways that would reduce the overall savings on the President's Budget.

Now if this committee heads your advice and disregards or modifies some of the Administration's proposal under their budget that would bring about savings, it may be necessary for us then to identify savings in other places and the physicians portion of Medicare. In the past we have always looked to you and others on the Com-

mission to help us shape these deficit measures so they would make sense from a health standpoint—a health policy perspective. And we will undoubtedly be doing that one again.

Now has the Commission in its deliberations identified any deficit reduction proposals not in the President's Budget that might have less adverse effects on the physicians payment reform?

Dr. LEE. First, we have not really reviewed the proposals fully before the Commission. We plan to do that at our next hearing, which would be the 26th and 27th of April.

The CHAIRMAN. Let me interrupt here for the benefit of my colleagues. I want to put a 5-minute limitation on each of us and witnesses in order that we can get through the witnesses that are here for us today. We have some excellent ones.

Dr. LEE. The first thing, I would say is that you need to take a careful look at the CBO assumptions and particularly our analysis and the staff analysis of those assumptions which we think really affect the overall budget savings targets that might be imposed on this committee from the Budget Committee. So that would be the first thing.

Second, we believe that the MEI update, from the standpoint of broad policy, has the least disruptive effect on the overall progress towards fee schedule reform. In other words, that's an area that we think might lend itself to some further examination.

A third area is in the proposal the Administration has made with respect to health maintenance organizations in providing 100-percent payment under the AAPCC, and there is an $80 million area. We think that before you make that kind of concession there would need to be some reforms in the way the AAPCC is calculated, particularly to take enrollee medical needs into consideration with respect to payments. That is an area that we could conduct some additional analysis for you.

We also believe that the proposal by the Administration for prior authorization for carriers is an area that we think is very important. It could either be carrier prior authorization or PRO prior authorization; and that is an area we could again examine in more detail and perhaps there would be greater savings there than had been projected by the Administration.

There was also a GAO recommendation—a recent report—which also recommends that reform as well as being in the Administration's budget proposals. We also think in the area of radiology and anesthesiology, that's an area that we need to look at more carefully; and although we do not support the Administration's proposal with respect to assistants at surgery, there may be some alternative policies that could achieve significant savings in those areas we well.

The CHAIRMAN. You know, Doctor, we are in a real time squeeze. I was meeting with Chairman Sasser on the Budget Committee, talking about the budget resolution and trying to get our data to them as are the other members of the other committees. So in that time squeeze, and wanting your information and thinking that it very well might be helpful, can you give me some feel for when you would have that back to us?

Dr. LEE. Well we can do two things, Mr. Chairman. One is we can provide information on the short term. Basically, we will do

the analysis and forward it to the committee. We would then take that information and put it before the full Commission at the April hearing. But as we do the analysis, we can provide the analysis to this committee directly and then, of course, we will give you the Commission's actions after the April meeting. So that we could do that—some of it could be done on a very short term basis—I mean getting it to you in a matter of weeks.

The CHAIRMAN. That would be helpful. Dr. Vladeck, on the question of rural hospitals, as you noted this committee has been very much involved in that and Senator Dole, and myself, and Senator Baucus, and a number of others on the committee have joined in trying to see what we can do to cut down the closure of rural hospitals. As I recall last year I had 13 hospitals close in my State; and 10 of them were rural.

Now you're recommending a faster schedule for the urban/rural differential. Instead of taking the full 5 years, you recommend doing it in 3 years, as I understand. I guess that would also mean that we would have to give further consideration to urban hospitals insofar as they have higher costs associated with greater severity of illness.

Do you have any other suggestions that we might make in that regard? Do you think that improving the measure of severity of illness would sufficiently mitigate the effects of a 3-year phase on urban hospitals?

Dr. VLADECK. Well, Mr. Chairman, one of the other suggestions that has been made relative to this issue is, as you know, is the possibility of removing certain categories of small rural hospitals from PPS altogether and putting them back on something more like a cost-based system. We are reviewing that. We have a mandated report due by the 1st of May. I wish I could tell you what we are going to recommend. We do not yet know. But personally, I cannot speak for the Commission yet which have not acted, I have real questions about the appropriateness of continuing to maintain hospitals of say fewer than 50 beds, or whatever, on the PPS system at all. I think the logic of the system does not work for them.

The CHAIRMAN. The averages just do not apply if you have a hospital with 35 beds. They have substantial cycles in the occupancy and the use of those beds.

Dr. VLADECK. That is my personal view as well. But as I say, I cannot yet speak for the whole Commission on that issue.

The CHAIRMAN. I see my time has expired.

Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

Dr. Lee, is it fair to say that the impression we should take from your recommendations is that this would be a good year to sort of not get too active in adjusting physician payments?

As I look through here there's a lot of caution. It starts off by saying that all the effort that went into physician payment reform ought to be left to do its work. A lot of the research that we knew was imperfect needs to get done. And that to some modest degree some of these adjustments might be made. But your basic advice to us is that the most important thing we are doing starts on January

1, 1992 and goes over a 5-year period of time and do not try to make money off of reform on doctors the way you did on hospitals.

Dr. LEE. Correct. As an overall statement of policy, that reflects the Commission's view.

Senator DURENBERGER. Is there anything, again, given the way we are forced to do things here where we are doing policy decisions on budget bills, is there anything that I haven't noticed or we haven't noticed that really is essential policy reform that we ought to do during 1990 or should we just do our regular budget thing and adjust them?

Dr. LEE. I think there are some fine tuning things, for example, on things like global fees for surgery. We will be making some recommendations to you in that area. Because we have carefully analyzed that and have got some recommendations. But except in some of those areas which I consider to be not major policy issues but they are important, other than that I would say I do not believe so.

Senator DURENBERGER. Okay. Thank you.

Dr. Vladeck, as far as PROPAC is concerned, obviously the annual target of opportunity is indirect medical education adjustment. Now we have a figure which is as low as any I have seen, which is 3.2 percent. It makes it a wonderful opportunity to make money. So the question is whether that money, if we bought into that, the money was going to be used for deficit reduction some place in the overall; or if you recommend, if you are going to reduce it to your 6.8 percent or you are going to reduce it at all, make sure that it shows up somewhere else in hospital reimbursement. Your recommendations being the savings to the standardized amounts for all hospitals.

Let me just ask you in light of what you said about teaching hospitals, there is nothing in here, at least that I have noticed in a quick running through it, about disproportionate share adjustment. What you said is the obvious, I think, for at least most teaching hospitals, that they carry a large burden of uncompensated care that they do take care of—the tough cases—or at least that is a presumption—for low-income persons.

Should we be looking at something more specific to spend that one on, say, in the disproportionate share area; and should we be looking at disproportionate share in a broader sense than simply the bigger, more urban hospitals? There is a lot of disproportionate share activity going on in West Texas and rural Minnesota and a lot of places like that. There are a lot of Medicare patients, a lot of poorer folks that do not really get cut in on the disproportionate share adjustment. What are your thoughts there?

Dr. VLADECK. Well I think, Senator, that is exactly the right issue. But we have on the Commission struggled with the issue of just how far can Medicare payment policy be used to address more systemic or more general problems in the health care system. Frankly, we think we have gone way past the Administration's point of view relative to that. We do explicitly, in our recommendations for this year, take into account the overall well being of hospitals, some of which arises from their provision of services to uncovered persons or to Medicaid recipients.

On the other hand, I think it is fair to characterize the Commission as being concerned that over time Medicare payment is not

the way, we as a nation, want to address these issues. And you can only stretch the Medicare system so far without beginning to create other sorts of problems if you want to solve that particular problem through Medicare payments.

Senator DURENBERGER. The way I interpret that is that whether we use indirect—all of these proxies are defective. I mean they do some good, but they spread a lot of money in places where there might be a more appropriate way to take care of it, whether it is education or the disproportionate share. Right?

Dr. VLADECK. I think that is fair. There is a very substantial overlap between disproportionate share and indirect medical education. That is the major reason that number has fallen to 3.2 percent.

On the other hand, neither adjustment is as yet surgically precise enough an instrument so that we could really fine tune it without having adverse impacts on particular institutions.

Senator DURENBERGER. This is on the issue of rural hospitals. Is it fair to say—and what I hear of your recommendation—that you are saying we are putting an awful lot of effort into using the PPS system for these very small primary care hospitals. Where we really ought to be putting our effort is into recognizing the cost impact on the larger rural hospitals which is a tremendous impact when the law of large numbers operates. And, that if we ever got to a national average, between urban and these larger rural hospitals, that this would be a fair way of reimbursing them because what they do is quite comparable, and leave all these small hospitals out of the PPS system. Is the——

Dr. VLADECK. Well again, sir, that is, at least until May 1, my personal view and not yet a Commission position.

Senator DURENBERGER. All right.

Dr. VLADECK. I think the other issue that has gotten very clear to us and one of the reasons, frankly, we recommended 3 years as opposed to 5 for a transition is the more we look at this the more some relatively technical problems with the wage index appear to be causing a lot of problems for the rural hospitals. And if HCFA is supposed to be revising that, if we could straighten out the wage index, then maybe some of these other problems would seem less severe and maybe we would not need to be in such a hurry to equalize the standardized amounts.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Lee, you have expressed some support for the concept of reduce payment for overvalued localities. You say the Administration goes a bit far. The question I would have of you is whether we could approach the concept of paying more to undervalue localities. Let me be specific.

In Charleston, WV, for example, anesthesiologists, who obviously are going to be reduced under RBRVS, are paid a lot less relative to peers in directly neighboring States—for example, the anesthesia conversion factor of $13 in Charleston compares to $20 in Ohio, to $18 in Pennsylvania, to $17 in Virginia, which is a disparity of 25 to 35 percent. I just wonder if you have thoughts about that—

undervalued localities and adjustments to be made potentially within them.

Dr. LEE. During the period when we were considering various recommendations with respect to geographic multipliers in the fee schedule that, of course, was a major concern—was both rural areas and then these communities that you might say are in undervalued areas. It is our view that with the fee schedule and with the geographic multiplier, with the correction factor that will occur with the fee schedule from 1992 to 1996, those inequities will be corrected. So that the course that you have already established we think is a very sound one with respect to dealing with that problem.

If we find in the course of that implementation that that in fact does not occur, then we should revisit that question.

Senator ROCKEFELLER. So you are suggesting that overhead costs, liability costs, et cetera, are going to be sorted out through the fee schedule?

Dr. LEE. With the fee schedule's correction for the geographic cost to practice factors, we believe that those inequities that certainly exist now, and in some cases are very serious, will be corrected because of the nature of the fee schedule and the corrections that go between the specialties—the ones that overvalued and the ones that are undervalued.

Senator ROCKEFELLER. That will be very important then to watch, won't it?

Dr. LEE. Absolutely.

One of the reasons we think the current Beneficiaries Survey that HCFA will be implementing is very important is that we want to also observe any adverse affects that may occur on access for beneficiaries. That is why we felt so strongly that that survey should be adequately supported.

Senator ROCKEFELLER. Let me ask both of you a question on hospital reimbursement. The Administration again has called for cuts in teaching hospitals, across-the-board cuts. Now, keeping in mind the goals that we have for physician payment reform—I mean you cannot say that doctors are over here and hospitals are over here, and the twain never meet. There is obviously a relationship.

Does it make sense to either of you to reexamine our program for paying teaching hospitals and draw, in fact, distinctions between different types of graduate medical education programs? For example, would it make sense for Congress to consider exempting primary care resident programs from reductions in payments? Should we treat different specialties differently because of public policy goals we are trying to achieve through RBRVS?

Dr. LEE. The Physician Payment Review Commission, as you know, has not been formally asked to deal with that issue. But as a personal comment, I would agree with what I think you are saying. That is that there are certain specialties—primary care specialties—should in fact be exempted, and should be reimbursed adequately for the costs of those residency programs.

There are a number of specialties that are, in my view, in oversupply. These are medical subspecialties, as well as some surgical specialties and subspecialties. And in those cases, reductions, it seems to me, are appropriate. In other words, this committee ought

to be concerned with manpower policies because downstream if you just unrestrictedly support those residencies, as you have in the past you are simply compounding the problem that you have to deal with in terms of costs of 5 years from now.

So I think that for this committee to take a look at that would be a very wise thing to do.

Senator ROCKEFELLER. Dr. Vladeck?

Dr. VLADECK. Well let me say three things very quickly if I might. First, we have focused a lot of attention on the indirect medical education adjustment over the last several years. It is just now that the limitations on direct medical education payments that were enacted a number of years ago are taking effect. I think within the next year we need to look very hard at the whole treatment of direct medical education expense and obviously variable payment for different kinds of residencies could be part of that.

Similarly, as obviously the members of this committee know better than anyone, the single most complicated payment issue in Medicare's history has been the relationship between A and B in teaching hospitals. I think it is probably, with payment reform, time to revisit that as well.

And then the third related issue that is you cannot encourage primary care teaching unless we do something about outpatient payment systems. We will be talking about that over the next number of months. But unless the financial base is in the outpatient payment, you cannot sustain a teaching program that is based around outpatient services.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. Thank you very much, Mr. Chairman.

I would like to ask about the extent to which any of you believe that Medicare is now really being subsidized by other health care payors. Because, you know, we have this absolute skyrocketing of non-Medicare rates. I wondered if you saw it in that light.

Dr. LEE. Again, this has to be a personal view, Senator, not the Commission's view, because again the Commission has not been asked to address that question.

But my personal view is that Medicare is not being subsidized. The fact is that in the United States on a per capita basis we spend 40 percent more than they spend in Canada for medical care. We have a system that is very inflated in terms of the resources that are allocated to it; and the fact is that the private sector has not responded as Medicare has in order to contain costs more effectively means that those premium costs have risen. But I think it is the failure of the private sector to respond, rather than Medicare cross subsidizing or the private sector cross subsidizing Medicare beneficiaries.

Dr. VLADECK. I think on the hospital payment side, it is very clear to me that in the first 4 years of the prospective payment system Medicare subsidized the private sector. Medicare margins were twice as high as total margins which meant that hospitals were making money on Medicare and losing it on their other business.

That is no longer the case, although the extent to which that has swung in the other direction is not clear to me with one exception.

That is, in a number of States it is very clear that in the teaching hospitals Medicare is subsidizing Medicaid. Now some of us might think that is about time. The beneficiary of Medicare generosity to teaching hospitals, is primarily the Medicaid program.

Senator BRADLEY. But as you say, in the real world that still puts them at the bottom.

Dr. VLADECK. That is even so; yes, sir.

Senator BRADLEY. So how do you account then for this non-Medicare skyrocketing of rates?

Dr. VLADECK. I think it is——

Senator BRADLEY. If you see Medicare being cut back, cut back, cut back, cut back; and you see the non-Medicare rates going up and up and up, it is reasonable to assume that one is paying less, the other is paying more. There has to be some kind of indirect subsidy there?

Dr. VLADECK. My impression is that as has been the case in Medicare overall, in fact, private insurance payments to hospitals, while going up faster than Medicare payments, have not been the principal engine driving the premium increases. That the principal thing going on as I understand it has been that all of our brilliant efforts in the 1980's to save money by moving services to free-standing centers or to physicians offices and so on and so forth have cost the private insurance market a fortune, as well as having an impact on Medicare Part B costs as well. And that the biggest growth sources are out of hospital expenditures of a variety of kind. And that is what is driving the premium increases for private health insurance.

Senator BRADLEY. Would you describe the kinds?

Dr. VLADECK. Well everything from the very substantial growth of diagnostic procedures in physician offices or physician-owned free-standing settings of one sort to increases in pharmacy costs and other ancillary costs—diagnostic radiology and things of that sort—on an outpatient basis have been the fastest growing piece of the cost part, right behind the administrative costs associated with competition and decentralization and all of these new entities out there controlling costs.

Senator BRADLEY. Dr. Lee.

Dr. LEE. We also know on the physician side, Senator, that prices have increased significantly—well above the consumer price index. And second, of course, volume of services in selected areas, particularly which are technology driven. And because there is no restriction on the introduction of those technologies, often no evaluation of their effectiveness, let alone cost effectiveness for procedures, that the growth there has been very, very dramatic.

Senator BRADLEY. You think that is because of—the rapid increase in price above the Consumer Price Index you think is due to the introduction of technology?

Dr. LEE. No, I think it is due to the fact that physicians are charging more. There are two theories, of course, about this. One is whether the market is really working or whether they have a target income. The target income theory is one that suggests that they raise their prices to accommodate an income goal.

Senator BRADLEY. Dr. Vladeck, you said that you felt Medicare was subsidizing Medicaid; and you thought that that was not alto-

gether a bad thing. Do you think we should really seriously look at increasing Medicaid reimbursement?

Dr. VLADECK. I think—and with Senator Rockefeller sitting here, in terms of the Bipartisan Commission—I think it is increasingly clear to many of us that the systematic reform in health care financing we need in the United States has to start with the Medicaid program in a variety of ways. I am all for increasing the requirements for say disproportionate share payments under Medicaid. I am very much supportive, perhaps somewhat parochially, of the proposal that has emerged in the House to have an AIDS disproportionate share payment under Medicaid programs mandated.

But it seems to me that there is growing—I am not telling any of you anything new when I say that if we are going to straighten out health care financing in this country, we have major issues around Medicaid and those have to be addressed very soon.

Dr. LEE. There is one other issue, Senator Bradley, and that is of course the increased physician supply which is progressing very rapidly. And as we increase the numbers, and particularly as we increase the number of specialists who generate more charges than generalists that is another factor in these expenditure increases that are both overall and relating to Medicare.

And, in fact, of course, we have not cut back Medicare. You simply lowered the rate of increase rather than actual cutbacks.

Senator BRADLEY. Thank you.

The CHAIRMAN. Thank you.

Senator Packwood?

Senator PACKWOOD. Dr. Vladeck, in a bill involving rural health I have suggested that we eliminate the urban/rural differential by January 1. You indicated that PROPAC suggests 3 years and certainly not the 5 years that is in the law now.

Is your suggestion for 3 years simply a financial one or is there any reason, other than money, why it could not be moved to 1991?

Dr. VLADECK. If I may, sir, I think there are two issues. One is, if you are going to move it up all our recommendations are on a fiscal year basis and there is a lot to be said for doing it consonant with the fiscal year. But there is a concern on our part. As I said, we are increasingly of the view that much of the problem that has occurred with rural hospitals under PPS has to do with the Medicare wage index and the way we treat wage adjustments for rural areas. That is something that is now being revised.

It is possible that once that revision takes place we will recommend that it is not necessary to phase out the difference between the standardized amounts, that in fact the problem all along has arisen in the way we do wage adjustments.

Similarly, it is clear that one of the major things that has been going on since PPS started has been that we, or you, keep shrinking the difference between the standardized amounts, but the difference between case mix keeps increasing. As we refine case mix measures—and particularly over the next several years as we look at relatively major reforms in the DRG measurement system—it may well be that much of the problem of rural hospitals has been there as well.

So our sense is that within the next 3 years we should be able to much better address the wage index and the case mix measure-

ment index. That is the point at which we will be able to make a much more definitive determination on the appropriateness of the standardized amounts issue.

Senator PACKWOOD. Just as I came in you were talking about hospitals with 50 beds or less. I did not quite hear what you said.

Dr. VLADECK. Well we have been asked, I believe, to look at the issue of whether those hospitals should be exempted from PPS altogether and put back on some variation of a cost base system. We owe you a report, sir, by the 1st of May.

Senator PACKWOOD. But you were not suggesting closing them if they had 50 beds or less?

Dr. VLADECK. No, no, no. I was suggesting my personal view that they were not to be on PPS at all, but that does not mean they should not get paid at all. [Laughter.]

Senator PACKWOOD. Dr. Lee, let me ask you a question in response to what you said to Senator Bradley. I believe he asked you if private patients are subsidizing Medicare. You said one of the great problems is that private industry has not been tough enough in terms of costs.

Dr. LEE. Right.

Senator PACKWOOD. In rural hospital hearings that I held throughout Oregon, hospitals whose gross was 55 to 60 percent Medicare claimed they were not breaking even on Medicare reimbursement. If they are not breaking even on Medicare reimbursement, and if the private sector got tougher so that hospitals got less reimbursement on private pay patients, how would that help the rural hospitals?

Dr. LEE. I think that we need a policy across the board. You cannot have piecemeal policies—Medicare with one set of policies, the private sector with another set, and Medicaid with another. Medicaid is grossly underpaying those rural hospitals in most States. So that unless you have an across the board policy, and one that is consistent so that Medicare policies are the same as the private sector with respect to fee schedules for physicians, you cannot solve the problem in my view. We will continue to have this yo-yoing. And when they say they lose money, it depends really, of course, on the resource inputs into the services.

There are many physicians who are seriously, I think, underpaid, even by Medicare, often in rural areas, often general practitioners, because they are under the CPR system. Their payments were set at a time when they were significantly lower. They have not been updated. So that there are very serious inequities. That is, of course, the reason that we recommended the comprehensive reforms for physician payment.

But Medicare cannot do it alone, just as Dr. Vladeck said, with respect to the hospitals. So that we need, I think, a look at this across the board, not just program by program.

Senator PACKWOOD. In your testimony you indicated that the fee schedule would be about two-thirds implemented by 1992.

Dr. LEE. Correct.

Senator PACKWOOD. In that case, why would there be any significant disruption if the rest of the fee schedule were hastened?

Dr. LEE. Well we think that that is going very rapidly to do it to that extent by 1992—69 percent by 1992 is a very rapid——

Senator PACKWOOD. Whatever disruption may occur, a whale of a lot of it is apparently going to occur between now and 1992.

Dr. LEE. It will occur between and it will occur by 1992. We think so.

Senator PACKWOOD. So there is no harm in a little more disruption? [Laughter.]

Just speeding things up?

Dr. LEE. Well we would have very serious concerns about that, Senator Packwood, for two reasons. One, because of possible access problems. And second, because it does not provide the private sector time to consider—and we hope adopt—the Medicare fee schedule, which we think would be a sound course for private payors to follow.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, gentlemen. Let me say you can see how much interest was evoked by your testimony and the concern of the members here. You have been very helpful to us. I note we had devoted an hour to the comments and the questioning. I also note I have six more panels. Thank you very much.

Dr. VLADECK. Thank you, Mr. Chairman.

Dr. LEE. Thank you.

The CHAIRMAN. Our next panel is Dr. Carol McCarthy, president of the American Hospital Association, Chicago, IL; and Mr. Robert Van Hook, who is the executive director of the National Rural Health Association, Kansas City, MO.

We are very pleased to have you. Dr. McCarthy, would you lead off with your statement.

STATEMENT OF CAROL M. McCARTHY, Ph.D., J.D., PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, IL

Dr. MCCARTHY. Thank you, Mr. Chairman. I would like to begin with a thank you. During the budget deliberations last year this committee acknowledged the increasingly fragile situation of hospitals and the link between that situation and the care that hospitals provide. We are very, very grateful for that; and again, we are here for your help.

There is no better example of a short-term budgetary consideration that is going to have some untoward long-term consequences than the President's projected spending for Medicare for hospitals in fiscal year 1991. If we take those funds from the dedicated trust fund, add these cuts that are proposed to the $18 billion worth of cuts that have been taken out of the hospital system since the PPS payment began, we are not only going to be jeopardizing care to Medicare beneficiaries, but, in fact, creating problems for all of us who rely on the hospital system in time of need.

There are some disturbing facts that must be recognized. The first is that without any projected cuts in fiscal year 1991, the average hospital's Medicare margin will be between a minus 8 and a minus 11 percent. Without any cuts in fiscal year 1991, 70 percent of all hospitals will lose money when they treat a Medicare patient; 50 percent of those hospitals will lose more than 10 percent; and 1 out of every 4 hospitals will lose more than 25 percent.

The second fact is that if the President's package of cuts is enacted, those payments by Medicare would be reduced an additional 6 percent.

The third is important and a direct response to the question that Senator Bradley raised. Already the cost shift to private payors for underpayments by Medicare and Medicaid is 10 percent, and when that is added to the cost shift attributable to unsponsored care, we are putting an additional 20 percent in total to the private payor's bill. That fact is threatening the very viability of our private insurance system today.

And lastly, we are not talking about an industry with costs out of control. We are not talking about a hospital field that can sustain these kinds of cuts through improved efficiency. Since 1982 hospital services, both inpatient and outpatient added together, have constituted between 4.2 and 4.4 percent of our Gross National Product. They have held at that rate despite an older and sicker inpatient population, despite the upsurge in AIDS, despite skyrocketing salary costs for needed manpower in hospitals, despite new and costly medical advances, and despite the inexorable rise in the other goods and services that hospitals have to purchase if they are going to provide the care that is required.

And still the President calls for a price update factor of 4.1 percent, when the Government itself estimates, in a market basket that does not even reflect hospital wages, that that market basket will increase by 5.6 percent. When we will have a 1.7-percent increase in Medicare beneficiaries, leading to the same level of increase in cost.

And the President's proposal does not stop there. He calls for a 10-percent cut in outpatient payments, when PROPAC already estimates that hospitals are losing 19 percent on ambulatory surgical rates. A 10-percent cut in outpatient payments is going to be particularly severe for our rural hospitals that in their reconfiguration have moved a greater portion of their services over into the outpatient area.

The Administration also proposes a 15-percent cut in capital payments to rural hospitals and to increase that cut to 25 percent for our urban hospitals. Not only are the past obligations that these capital payments cover not subject to modification, but this policy would turn all capital acquisitions that are made in response to patient care considerations into losing propositions, as well as erode the hospital's creditworthiness.

The Administration also proposes such deep reductions in our teaching hospitals' direct and indirect, medical education payments that if you add those to the other cuts, the averaging teaching hospital would have a negative minus 13 to minus 16 percent margin in fiscal year 1991, and that translates into a loss of more than $300 for every Medicare patient that teaching hospitals serve.

Quickly a few words on Medicaid as well, because the program does need substantial repair—both in its eligibility requirements, its enrollment incentives, its financing and its reimbursement. And this year's call by the Administration for $25 million in additional outlays is not going to address any of these dire needs. At a minimum, we need to look toward the development of a minimum payment standard under Medicare. The reimbursement under the pro-

gram has gotten so bad that we are actually talking about payment floors.

Let me conclude, if I may, simply by saying that on behalf of hospitals and all those they service, the American Hospital Association asks that this committee recognize the dedicated nature of the Medicare trust fund, that it is a "trust" fund; and the Medicaid's program importance to the poor people in this country; and call for adequate payments for our hospital facilities.

Thank you very much.

[The prepared statement of Dr. McCarthy appears in the appendix.]

The CHAIRMAN. Thank you.

Mr. Van Hook?

STATEMENT OF ROBERT T. VAN HOOK, EXECUTIVE DIRECTOR, NATIONAL RURAL HEALTH ASSOCIATION, KANSAS CITY, MO

Mr. VAN HOOK. Good morning, Mr. Chairman, members of the committee. I am Bob Van Hook, executive director of the National Rural Health Association. I am very pleased to be here on behalf of the NRHA's national membership. Last year Congress included a host of provisions in the 1989 Reconciliation Act to improve the delivery of health care services in the rural area.

Several of the provisions that were included last year were originally in legislation that you, Senator Bentsen, and Senator Dole introduced in early 1989 to kick off the session; and other parts were spurred by initiatives introduced by other committee members.

The entire Senate Finance Committee has been instrumental in seeing that these initiatives were enacted and the committee has traditionally been a good friend of rural health. And on behalf of rural America, I want to thank you for all your work in the past and that appears to be continuing this year.

Although significant progress was made last year in improving the programs affecting rural health care services more remains to be done. Most importantly and absolutely first, NHRA opposes the significant budget reductions in the Medicare program that the President has proposed. The Medicare cutbacks would be especially harmful to rural and inner city hospitals, their physicians and ultimately their patients. I want you to know that we have concern about the inner city hospitals too. We think rural hospitals share a lot of common problems with them.

The Administration proposes large cuts in the Medicare program. We specifically oppose:

One: the 4.1-percent update factor. The hospital updates must at least keep pace with inflation, otherwise they become cuts in payments; and clearly rural hospitals, the majority of which are already losing money on Medicare and which, by the way, have been losing money for several years now, cannot afford further Medicare cuts.

Last year Congress passed legislation requiring the Secretary of Health and Human Services to develop a plan for eliminating the urban/rural differential in Medicare hospital payments and that plan is to be implemented by 1995. However, many rural hospitals cannot wait until 1995 for implementation. The National Rural

Health Association believes that Congress should fully eliminate the remaining 7 to 8 percent urban/rural differential in standardize Medicare payments in the fiscal year 1991, as called for in Senator Packwood's recently introduced legislation. We understand that Senator Symms has introduced legislation last year.

We urge an immediate elimination of the differential because according to a study performed for us by Lewin Associates the cost to raise the rural rate up to the small urban rate is only $353 million. That is a low price tag for equity. The National Rural Health Association would oppose adjusting standardized rates based on current costs because chronically low PPS payments tend to depress costs over time. The old adage, "you can't spend what you don't have" holds very true.

While we have serious concerns about cost-based reimbursement methodologies NHRA recommends that Congress consider cost-based reimbursement for all rural hospitals, especially those under 50 beds. We understand that Senator Baucus is planning to introduce some legislation fairly soon in this regard. I was really pleased to hear Dr. Vladeck make those comments earlier.

Two: President's proposed 10-percent cut in outpatient payments is, as Carol McCarthy has indicated, going to be disastrous for rural hospitals. Studies indicate that in rural hospitals outpatient care is a higher percentage of total business.

Additionally, though, these outpatient payments are essential for helping maintain some of the essential services like emergency medical care. Recent outpatient payment reductions have hurt rural hospitals badly over the past several years, and we urge Congress to pay rural hospitals for outpatient services on a reasonable cost basis and resist those reductions proposed by the President.

Three: we are also opposed to the 15-percent reduction in capital payments for rural hospitals. Many rural hospitals were constructed during the 1950's and 1960's under the Hill-Burton program, and badly need renovation.

Additionally, without access to capital, rural hospitals may slip in their ability to acquire the technology that modern medicine demands. NRHA encourages Congress to increase the percentage of capital passed through for rural hospitals, rather than reducing those payments.

There are several other policy issues that NRHA urges the committee to consider, including the following: First, as Dr. Vladeck indicated, the area wage index is an important piece of the payment problem for rural hospitals. We are pleased that there is some work going on in that area. We consider it an even larger source of inequity than the standardized DRG payments. And we are supporting the National Advisory Committee on Rural Health's recommendation that the Congress enact legislation that would require the Secretary to implement a refined area wage index very, very quickly.

We are looking forward to working with this committee, PROPAC and AHA in devising an area wage index that will be equitable for both urban and rural areas.

Senator Packwood's Rural Health Improvement Act of 1990—S. 2214—and Senator Pryor's initiative last year focused on tax credits for primary care providers. We are very supportive of that

and the exemption of National Health Service Corps loan repayments from gross income. We think that would be very useful.

There are three other provisions in terms of payments for allied health professionals. One would provide direct Medicare reimbursement for nurse practitioners; another the establishment of a uniform fee schedule for certified registered nurse anesthetists; and finally, the last would remove some of the restrictions of physician assistant payment. We are very supportive of these provisions.

NRHA also supports the provision in Senator Packwood's bill that calls for review of hospital regulations for rural hospitals. We think that this is important and without a formal review process the burden of proof falls on rural hospitals. That is like the rural hospital tail wagging the very large HCFA dog.

We really appreciate the work of this committee in addressing the difficult areas of rural health care and we really look forward to working with you in the future and sharing the goal of improving rural health and rural quality of life.

Thank you, Senator.

[The prepared statement of Mr. Van Hook appears in the appendix.]

The CHAIRMAN. Thank you.

Dr. McCarthy, those numbers of yours were quite depressing when we think about quality health care.

Dr. MCCARTHY. Yes, Senator.

The CHAIRMAN. It is pretty obvious from what you have said you would be really opposed to any cuts in Medicare. But you know what happens on budgets and you know the drive that we have facing us now in trying to achieve what the Administration proposed to us.

Tell me those things that are proposed by the administration that you think would make it most difficult for you to provide quality health care. And is it just the size of the cuts or is it the policy direction that is disturbing you?

Dr. MCCARTHY. What we are faced with is years of sustained deep cuts. That is why, you know, it becomes exceedingly difficult as you look ahead for fiscal year 1991 to say, "Well we have some room, let's cut here." If you took the President's approach on the indirect medical education adjustment, which is as important for the factors that our DRG system fails to measure as it is for indirect MedEd, you would seriously jeopardize the continuation of our teaching hospitals existence.

The CHAIRMAN. Does that mean you think that is the most difficult?

Dr. MCCARTHY. I think that is not a good thing to do at all.

The CHAIRMAN. No, no, no, no. I understand. You don't think any of them are a good thing to do.

Dr. MCCARTHY. But what I am trying to show you is that anyone we pick——

The CHAIRMAN. We are going to have to make some choices.

Dr. MCCARTHY [continuing]. We are putting a system that is under stress under even greater stress. That is why I cannot do as we have been able to do, you know, years before, say "Well, if you were to take a little bit off here, it is not going to be felt that

much." Right now, these cuts are going to be badly felt. I wish I could do more.

The CHAIRMAN. Dr. McCarthy, I understand that it is going to be difficult, but we are going to have to make some choices. And we would like for you to help us in that regard. We think you have information that is value to us and I would like to know those things that you think will make it the most difficult for you to develop quality health care and deliver it.

Dr. MCCARTHY. I think, Senator, it will be very helpful to have the budget mark come down and know what we are dealing with, because we are dealing with such a delicate balance. There is not really going to be one place you can turn to to do this. The situation in the hospital system is such today that it just has not got something to readily offer up.

We can talk about whether we want to spread the hurt evenly or unevenly.

The CHAIRMAN. Well just remember, Doctor, when we do it we might have done it differently with your advice. We would like your help.

All right. Mr. Van Hook, we appreciate your testimony. But my understanding is from CBO that when we talk about closure of the rates, urban/rural, that the number is closer to $400 million and not the Lewin Associates report that you have at $350 million. I am not sure that you just don't want to trust the CBO or I am not quite sure why you spent that much money when you had those numbers available.

Mr. VAN HOOK. Well, sir, we haven't seen those numbers. Everyone had been saying $750 million and that was the only number anyone would talk about. I would ask Don Young and I would get the same $750 million.

The CHAIRMAN. So that shook you up enough where you went and hired someone to run some numbers?

Mr. VAN HOOK. Absolutely. That is why we went out and hired someone.

The CHAIRMAN. All right.

Mr. VAN HOOK. We do not have that kind of money to throw around either, Senator.

The CHAIRMAN. Well you know how strongly we feel about trying to close the differential and we made some serious headway. If you remember when DRG system started we were talking about a 20-percent differential, as I recall, and now with things we have done, we have cut it down to 8 percent.

And you know I support the elimination of that differential.

Mr. VAN HOOK. And we appreciate that, sir.

The CHAIRMAN. But the problems of rural hospitals are not going to be solved by that last 8 percent. Because I have been listening to these numbers that you have been giving me.

We offered a provision last year for those small rural hospitals most dependent on Medicare to help cover their costs, and I know you support that kind of an approach. But the House is extremely resistent to our going to cost reimbursement for these rural hospitals, even on a time limited basis as the committee approved.

Are there other avenues we ought to consider instead of just cost reimbursement for them?

Mr. VAN HOOK. I think some of the things that were done last year in terms of the Eessential Access and Rural Primary Care Hospital programs were attempts to provide options for hospitals and they may turn out upon implementation, to be useful. I think PROPAC is beginning, to recognize that the small rural hospitals are going to have a difficult time dealing with prospective payment no matter how much equity there is in the system. This may bring about a push in the House for going to cost-base reimbursement.

I think fixing the area wage index and resisting the cuts in outpatient services are two essentials. There are much bigger problems for us now than the 8-percent differential.

The CHAIRMAN. Thank you.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. McCarthy, both you and Mr. Van Hook have stressed the problem of capital cost. It is a very difficult and very hard issue, but it comes up every year. I have not sat on this committee very long, but it comes every year and every year there is a fight and the fight takes a long time—somebody wins; somebody loses.

Congress in the meantime has instructed HCFA to fold capital into DRG, and to do that by 1992, and Dr. Wilenski is proceeding at pace with that. My question of you would be: What is the AHA's position on capital being rolled into DRG payments? And no matter how you answer that, wouldn't it be better to develop some kind of a formula to work off of, rather than going into this every single year? And if so, how would such a formula be constructed?

Dr. MCCARTHY. I guess the basic is why do——

Senator ROCKEFELLER. Maybe you could do the first question first.

Dr. MCCARTHY [continuing.] What is it we are seeking to do. I can tell you that we are ready to work with Dr. Wolinski on looking at incorporating capital into the price. She has offered that opportunity and we intend to be there sitting around the table working with her. It is very important that we do that. Because I will tell you that since this issue first came up the American Hospital Association has devoted incredible resources to trying to find a way to incorporate capital. And approaches that appear superficially at least to be workable in fact end up creating major problems because of the vastly disproportionate places hospitals are in their capital cycles. And so this is an extremely difficult thing to do, not an easy thing to do.

We have not found the way to do it, to be absolutely up front, frank with you. We have not found the way to do it. We have looked at alternatives, if the idea is to try to put an incentive into capital payment. And we have some of those we want to discuss with the Health Care Financing Administration.

If, in fact, what is being looked for is simply a way to effect some budget savings, then what we are currently doing to hospitals—that is denying all of them 15 percent reimbursement across the board—is producing the dollars without producing massive disruption in capital cycles. Please do not take that to understand that I think that at a time when you want to change your hospital industry, at a time when you want it to be shifting over to new uses, that this is the time to fail to pay for even past obligations. But if

the goal is cost savings, then the current method of reducing outlays at least does not present massive problems.

So incorportation is just one of those things which superficially looks awfully good. But when you get down technically to how you would actually do it I am——

Senator ROCKEFELLER. In effect, you would really rather fight year by year because there is a fear that a formula might have a budget saving philosophy to it and therefore lock you into something?

Dr. MCCARTHY. No, no. That is not what I meant to imply at all. Any formula you could fight for year by year in any event. That is what we do when we are talking about the DRG formulas. What I am trying to say is that incorporating capital, because of the nature of the facility's obligation where a particular facility is in its capital cycle and how it has funded its project—creates actual technical difficulties in devising a formula. We have not been able to devise a formula that at least starts out with some equity in it so that whatever its future, we are not creating more problems rather than solving them.

Senator ROCKEFELLER. All right.

Also, your position on cost-based reimbursement for rural hospitals?

Dr. MCCARTHY. The AHA supports cost-based reimbursement for hospitals with fewer than 50 beds because the DRG system is a system that is based on averages. And when you're dealing with our very small hospitals and you're dealing with the very small caseloads they have, the average system just does not work.

We do not believe that were you to enact that which we believe you should tomorrow, that you are enacting a policy that is going to keep every rural hospital alive no matter what, because you are not. You are just getting at a way of dealing with a group of hospitals that cannot operate under an average system because they just do not have the numbers to make the averages work.

Senator ROCKEFELLER. A final question. If there were in fact universal health insurance—and in fact one of the things that people have not yet particularly noticed in the Pepper Commission recommendations is that the Pepper Commission doesn't just suggest that it would be nice if people had health insurance, it says that they ought to. It is not a choice.

To what extent, understanding that Medicaid is the disaster that it is and Medicare does not do the job either for hospitals, to what extent would that be helpful? If there is a way of you expressing that on a percentage basis, it would be helpful.

Dr. MCCARTHY. To what extent would universal access be helpful?

Senator ROCKEFELLER. The making up of the losses that you put out here in your testimony.

Dr. MCCARTHY. Currently uncompensated care represents 6.7 percent of all hospital revenues. And unsponsored—meaning after even a tax appropriation from a local government—after you take out any dollars contributed whatsoever, you are still at approximately 5 percent of all revenues for hospitals that are foregone. So that if we conceivably provide people with financial access to services we can make substantial progress toward eliminating that

shortfall. But we will do more for the uninsured because that 5 percent is just those costs that are now incurred by people who make their way into the system. There are so many people who never make their way in because they do not have financial access.

Senator ROCKEFELLER. Mr. Van Hook, could you give a comfortable response?

Mr. VAN HOOK. Yes, I agree with Dr. McCarthy. Rural hospitals tend to have a pretty high percentage of uncompensated care and universal coverage would really be helpful. We would really like to see that.

Part of the problem is trying to patch up a patched-up system. We need big reform like the Commission has suggested.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Packwood?

Senator PACKWOOD. Mr. Van Hook, I appreciate your comments about my rural health bill. I would like to snap my fingers, produce it next week, and pass it. But it isn't all going to pass at once. If you had to pick out three parts that would be most critical to your group, what would they be?

Mr. VAN HOOK. The first has to be the National Health Service Corps, which isn't within the jurisdiction of this committee, but is——

Senator PACKWOOD. That is more important than the reimbursements on Medicare?

Mr. VAN HOOK. We absolutely must have the National Health Service Corps. You cannot have hospitals without doctors. We must have primary care doctors for rural America, and the Corps is an essential part of that.

The provision dealing with the hospital reimbursement equity is critical, too. We have to get that squared away.

I particularly like the tax incentives for the primary care doctors, including the exemption of the National Service Corps loan repayments. I think those are critical pieces. And I snap my fingers for them too.

Senator PACKWOOD. That is a very specific answer. I would have expected some other things to rank higher, but nobody would know this better than you. And so I appreciate it.

Mr. VAN HOOK. I will go back and look a little more carefully. That was off the top of my head.

Senator PACKWOOD. Well, take a look. Because we would be more inclined to listen to you in this area than to anybody else. I would hate to pick the wrong three, based on your advice.

Mr. VAN HOOK. I will get right back with you on that.

Senator PACKWOOD. All right.

Senator PACKWOOD. Now, Dr. McCarthy, I sense that you want to move to a uniform rate for reimbursement. But when Senator Bentsen, the Chairman, quizzed you on where we should get it, you basically said you need more money, rather than pare here and add there.

Dr. MCCARTHY. I am well aware that this is certainly not the place to be sitting to say we need more money. On the other hand, I have to say, we need more money. This is not the time to cut the hospital system. It is the time to invest in it. I wish I had another

answer. If I did, and if our data showed it, I would be more than willing to provide it.

Senator PACKWOOD. Let me rephrase what the Chairman is saying, then. I think we will not end up going as far as the Administration wants, but I would guess a $3.5 to $4 billion cut. We will tilt somewhat toward rural hospitals because we think they have been disfavored in the past. But so often this committee attempts to do something rationally, but gets no help from the group whose matter it is dealing with, and so must act on its own.

When you said that you'd like to wait and see the budget mark come down, or words to that effect, you would be way behind the curve if you did that. Once that budget mark comes down—once the committee makes the best decisions it can, and we just sweat blood to get to the $3.5 billion—then to undo it is almost impossible.

Dr. MCCARTHY. Senator, I would say this——

Senator MOYNIHAN. Would Dr. McCarthy please permit a brief interruption by the Chair for an observation. In response to your statement about needing more money, it should be noted that half the Senators present immediately left. [Laughter.]

Dr. MCCARTHY. That was not my intent either.

Let me respond this way. The reason I had said that was that we need your help in getting any reduction from that mark as low as it can go. Things are not—as low as it can go. When you know that mark it is a little bit easier to know how much pressure you could possibly put on each point. If you ask me now the best approach, all I can say is first get the cut as low as you can, and then don't go at any one segment with any heavy hand.

In other words, you are better off with a modest decrease in the update for everyone. Our rural hospitals are in bad shape, but our urban hospitals are in very bad shape. That is why I am saying, if it has to be, keep it as low as you can. And best to look at a modest reduction across the board, whether it is slightly less than market update, something off of capital reimbursement across the board, but not 25-percent cuts in capital reimbursement and the kinds of cuts that are in the President's budget. They cannot be sustained without real damage.

Senator PACKWOOD. If worse came to worse then, rather than being cut $3.5 or $4 billion, would you just have us go to Gramm-Rudman and sequester, where you would have a 2-percent cut? You would be better off.

Dr. MCCARTHY. On the mathematics, we clearly are. Even $2 billion. I am going to tell you, you are going to find now, in the eighth year into this program, that beneficiaries are going to feel the hurt.

Senator PACKWOOD. Thank you, Mr. Chairman.

Senator MOYNIHAN. Doctor, you will forgive me, having been absent for your oral testimony. I have seen your written testimony. I can only say and I say mostly for the benefit of my colleague, the former Chairman, Mr. Packwood, that in, what, now 14 years on this committee and having been involved in these matters, I was marginally involved in the establishment of Medicare from the Department of Labor's analyses. I have never seen hospital adminis-

trators in anything like the sort of almost dazed desperation they are now in.

They come to you from New York City where we have some of the great teaching hospitals of the world, hospitals whose schools of medicine go back before there was medicine—well before there was medicine—18th century institutions—the College of Physicians and Surgeons for example. Columbian Presbyterian will say to you, "I don't know if we are going to stay open." This in an 18th century economy which consisted of a level of wealth which we could not imagine—we would consider it subsaharan poverty today. But we could support those institutions nontheless. In this, almost 21st century economy, we cannot. There is something the matter. I mean something truly the matter.

Would you agree with what I have said?

Dr. McCARTHY. Unfortunately. Unfortunately.

Senator MOYNIHAN. We ask tough questions around here, Doctor.

Dr. McCARTHY. There is no doubt that the financial condition and the future for the health care field, the hospital field, has never been more threatened and never been in worse shape than today.

Senator MOYNIHAN. No. I have a note here of obvious consequence, I think. It says, in 1988, in New York State, "Thirty-four hospitals provided care to almost 80 percent of AIDS patients. These same hospitals had $740 million in aggregate operating losses last year." That is the point—their endowments. Some of which have been built up over two centuries. The New York Hospital was chartered, I believe, by George III, 1771 and their endowment having been built up over two centuries or more, is beginning to disappear.

Senator PACKWOOD. Mr. Chairman, I hear what you are saying and I am sympathetic. Having spent my law school career in New York, I appreciate the problem. But we cannot have our medical costs going to 13 to 15 percent of GNP. There has to be an answer but I don't know what it is. People say Canada or Sweden have the answer. I don't know.

I read and I talk to people. They like the system if they are not very sick but they don't like it if they have to wait; and they don't like it if they don't get great treatment. They get great treatment in our hospitals here.

I do not know the answer. But the cost of medical care just cannot keep going up as an ever increasing portion of our Gross National Product.

Dr. McCARTHY. It is a very complex challenge.

Senator MOYNIHAN. Let me ask the two witnesses. I have two hypotheses, and we better think about this. We cannot sit around here trying to legislate regulations and odd things. And Senator Danforth has raised the whole question of last years of life and the costs associated with that, which the culture has not learned to deal with. It is a new problem and a new opportunity.

Perhaps we are on a great "S curve" that has escalated and that we are up near an asymptotic point. Is that possible?

Dr. McCARTHY. I think what we are dealing with is an extremely complex system. We do need to take a look at it as a whole and see what types of reform we can introduce. But if you look at the types

of things that influence the costs of medical care in this country, everything from our liability headsets in this country and what that does to driving the costs of care, to in fact an aging and graying America who relies on health care services more than anybody else, to practice changes that go on all the time—medical miracles—and our need to know what works well and what doesn't work, and to reduce our outlays only to what works, to a system that is so fractionated that we do have a great threat, for example, in the private system right now because of huge increases they are seeing in their premiums that far exceed the increases in the actual costs of care.

So, you know, you have to sort it out, deal with it all.

Senator MOYNIHAN. Hypothesis. If we close the law schools, would we keep the medical schools open? [Laughter.]

Dr. MCCARTHY. That might help. That might help.

Senator PACKWOOD. Are you suggesting that as a desirable alternative?

Senator MOYNIHAN. I have the President of the most prestigious—well one of the most prestigious—universities in the world, located in New York City, recently observe to me the two things in which our economy differs from the Japanese and German societies. He said, they have no law schools and no business schools. And hence, no wonder their economy works well. That is what he said.

The second hypothesis. We had two epidemics strike in the 1980's simultaneously. You never get two epidemics at once. We got two at once. And we ought to see that we are going through a public health emergency as a result of them. AIDS—the first diagnosis of AIDS was about 1983. That is exactly the time that crack cocaine appeared in the Bahamas. The first article on the epidemic was in the "Lancet" and in 1985 said we were in the midst of an epidemic of crack cocaine—of free-based cocaine in the Bahamas.

The public health officials down there tried to tell us an epidemic was coming our way. But we didn't see it. Lawyers cannot see drug abuse as a public health emergency. They just want to put everybody in jail. And now the Navy wants to blockade Venezuela or whatever. This has been ruinous. If it were something more recognizable as a viral disease we would say, oh, I see, we got two viral diseases at once.

Medicaid does not reimburse any treatment costs for crack cocaine. A pregnant woman using crack cocaine goes to the hospital and they can treat her but they will not get any help from Medicaid, because we don't see this.

What about the two epidemic hypotheses? Mr. Van Hook, why don't you answer?

Mr. VAN HOOK. Well clearly rural has a share of both of those problems.

Senator MOYNIHAN. Of course.

Mr. VAN HOOK. Approximately 8 or 9 percent of the AIDS cases are diagnosed in rural areas and we think there are a lot more that are coming back home to be treated in rural areas.

Senator MOYNIHAN. You would describe this as an epidemic, wouldn't you?

Mr. VAN HOOK. Oh certainly, no question about it. And both of them would have——

Senator MOYNIHAN. You would certainly, but we don't see it around here as an epidemic.

Mr. VAN HOOK. And they have societal and health care costs. They are both eating us up both ways, and we have to find some way to deal with it.

Senator MOYNIHAN. Dr. McCarthy, would you please respond?

Dr. MCCARTHY. It's one of the things we don't even think about as a society at large. We have border babies now—part of this whole upsurge in crack use.

Senator MOYNIHAN. Sure, that's what I mean.

Dr. MCCARTHY. Their parents abandon them. The mother on drugs leaves a baby, and the baby is literally growing up in the hospital. We have to find a way to deal not only with ill babies, but with border babies as well. We have got really the medicalization of social problems in this country.

Senator MOYNIHAN. We have the medicalization of social problems.

Dr. MCCARTHY. Yes.

Senator MOYNIHAN. Would you accept the definition of crack cocaine as an epidemic? Does it not occur when an epidemic comes about when the normal restraining forces become weakened for some reason?

Dr. MCCARTHY. Under those circumstances I would. Yes, Senator.

Senator MOYNIHAN. You would. So you would certainly, I think, agree that Medicaid ought to reimburse treatment.

Dr. MCCARTHY. Oh, indeed. We also ought to look, I think, at some innovative program. Some of the States are looking to see, for example, even in the AIDS area, whether the State can be permitted to pay the private insurance premiums so that an individual can remain with their private insuror and only enter the Medicaid system, if at all, toward the very end.

There are a variety of ways we need to look at dealing with it, but we certainly have to take it on.

Senator MOYNIHAN. But if you have two epidemics, two simultaneous epidemics, which has never happened before—not that I know of—epidemics break, you know, and epidemics come to an end. They always have. But, we can't say when. We are in a rather extraordinary period of strain on the system. It would be nice to see somebody quantify how much of the strain in the system is a consequence of these two simultaneous—dual—epidemics of the 1980's and now 1990's.

Mr. VAN HOOK. Well part of what happens with the crack cocaine epidemic is the rash of homicides that occur.

Senator MOYNIHAN. It is much involved with it?

Mr. VAN HOOK. Right.

Senator MOYNIHAN. Sure.

Mr. VAN HOOK. Those have costs as well.

Senator MOYNIHAN. May I suggest that that's something that needs attention, that the medical profession has never treated drug addiction as a medical problem or have not liked it. When Vincent Dole developed methadone treatment for opium abuse he was, thank God, at Rockefeller University and had tenure, because he

was not welcomed. I wish I knew why. I wish the medical profession were interested. Why do they not attend to the single most obvious behavioral health problem in our country right now? They do not.

Nobody in our Public Health Service even heard people in the Bahamas saying there is an epidemic coming your way. Am I wrong?

Dr. McCarthy. I think they are hearing it now, Senator.

Senator Moynihan. Well they are hearing it now. It has come. But it does not fit the concept of medical.

Dr. McCarthy. That is true. Again, it gets back to that medicalization of social problems and therefore it is a different type of a problem and it has taken longer perhaps than it should have to be recognized for the big problem it is.

Senator Moynihan. But I mean in the end, you know, you have a lot of confidence in the profession. It gets better.

When do you say that the random patient with the random disease, encountering the random physician was better off for the treatment? What year do we locate that at?

Dr. McCarthy. I'm not sure I understand the question.

Senator Moynihan. Lou Thomas'—I mean, when did hospitals stop hurting people.

Dr. McCarthy. I see. That's in the category of whether I beat my husband every evening, and I don't think I probably should answer that one.

Senator Moynihan. Well you should. About 4 years ago, it will be 5 shortly, it was the 100th anniversary of the establishment of the American Association for the Advancement of Science "Science," which is our journal—I was once a member of the board and its vice-president—we had a little issue on the great developments in science in the century. And, you know, they are not hard to figure out.

But there are wonderful little essays on each. And Lou Thomas said, you know, what was the great discovery—the great invention, discovery, event in medicine. He said it's that we learned to stop hurting our patients. It took the whole of the 19th century to stop, you know, treatments that were harmful.

Lou locates this point about 1910. And since then you have had the extraordinary development of the ability to actually do something. But by 1910 doctors knew what patients typically had but they could not do anything about it, and they knew they could not do anything about it so they stopped drilling holes in skulls to let the vapors go away, or bleeding, or whatever.

But then came the onset of actual effective treatment. This was a new experience. So that may be something we are just getting used to and we can settle down with.

This seems speculative. But I am more interested in these things than I am in the regulations of taking one-tenth of 1 percent of the median inverted progressive regression and applying it to barrage storage depreciation.

Dr. McCarthy. I can't imagine why.

Mr. Van Hook. Well, Senator, for either because of choice or by the fact that they have been forced into it by payment systems and changes in medical practice, rural hospitals are becoming much

more "high-touch" oriented and are, I think, moving in the direction of taking better and better care of their patients anyway. I think there are great improvements being made.

Senator MOYNIHAN. Well the rural hospital—the nearest hospital to where we have lived for a quarter century in upstate New York—is a very good hospital indeed. But then some problems go away. They have not had a rattlesnake bite in a century.

Thank you very much. You are very helpful and you know the committee's heart is with you. What we will end up doing under the duress of the arrangements we have made for ourselves is another matter.

Dr. MCCARTHY. We greatly appreciate your help and support, Senator.

Senator MOYNIHAN. You are very kind, Doctor.

Mr. VAN HOOK. Thank you, sir.

Senator MOYNIHAN. And thank you, sir.

Now we have Ms. Janice Gruendel, who is appearing on behalf of the American Public Welfare Association and who is Deputy Commissioner of the Department of Children and Youth Services of the State of Connecticut.

Ms. Gruendel, you have the distinction of being a panel all your own. We welcome you.

Ms. GRUENDEL. Thank you, sir.

Senator MOYNIHAN. We welcome you and your testimony will be included in the record as if read. So you can go ahead and summarize as you wish.

STATEMENT OF JANICE M. GRUENDEL, ON BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, DEPARTMENT OF CHILDREN AND YOUTH SERVICES, CONNECTICUT

Ms. GRUENDEL. I want to begin with two notes that are not on my official list of things that I wanted to say. The first is that I've attended neither law school nor medical school.

Senator MOYNIHAN. I see. So we are safe from you.

Ms. GRUENDEL. You are safe from me. That's right.

Senator MOYNIHAN. All right. Good. This is important.

Ms. GRUENDEL. The second is that I have difficulty in doing things in 25 words or less. So giving me an entire panel of my own may cause you to suffer some, but I will try to be concise.

My name is Janice Gruendel. I am the Deputy Commissioner of the Connecticut Department of Children and Youth Services, a member organization of the American Public Welfare Association.

We have prepared detailed written testimony on the degree to which the Health and Human Services budget request falls short of necessary funding levels required to respond appropriately to this Nation's child welfare crisis.

In the few minutes that we have together today, I would like to do three things. First, I must tell you in a very real and personal sense about our children in crisis. Second, I would like to explain what Title IV-E administrative costs really are and why the Administration's proposed cap is unwarranted administratively, unfair across states and detrimental to children. And third, I would

like to make an invitation for you to see what its like to be a child protective services worker.

First, I'd like you to close your eyes and envision your own child or your grandchildren or the child next door or perhaps the last child you saw as you came in this morning to this session. And now I would like you to envision this child bruised or beaten or sexually assaulted or lying in a two-room apartment with drug paraphernalia on the table or making a suicide attempt.

For many people it is hard to make the intellectual and emotional bridge between the children that we all probably see every day and the children whose conditions I've just described. But I must tell you personally that thousands of people—child welfare people, children's mental health people, juvenile justice people, just like me———

Senator MOYNIHAN. See such children all the time.

Ms. GRUENDEL [continuing]. We hear the voices and see these faces every single day. I can tell you honestly that we go to bed at night and we feel these kids pain. The first 3 months that I was in this job I really didn't sleep; and when I did I was really captured by the pain that you feel when these children are visited upon you.

I carry a beeper 24 hours a day. I have watched babies die. There is no way to describe that. I would not recommend it for other people. I must tell you that once you have done these things, there can never again be a budget decision that does not have a child's face behind it; and that's the bridge; we must cross from an intellectual to an emotional understanding of these children's plight.

You all know the quantitative data as well as I do with regard to the needs of children. Child abuse and neglect continues to rise each year. Parental substance abuse, as you have so appropriately referenced, is a significant issue with regard to both the level of neglect and absolute abandonment of babies that we see everyday.

The number of children who cannot live in their own homes has increased 30 percent in the past 3 years. And we are not talking about 10 or 20 children, we are talking about 360,000 children annually who cannot live in their own homes.

Senator MOYNIHAN. Three hundred and sixty thousand?

Ms. GRUENDEL. About 360,000 children in the country. Poverty is such an incredible issues. In some of our cities one in two children live in poverty. Connecticut has the remarkable distinction of being one of the wealthiest States, on a per capita basis, and yet it has three of the poorest cities in the country. We need to deal with that dichotomy.

Senator MOYNIHAN. That is a pattern, Ms. Gruendel. That we know. In the city of New York, the richest per capita congressional District in the country is separated by about 10 blocks from the poorest little sliver of another, with a District in between. That is all.

Ms. GRUENDEL. That is a national travesty, I think.

Senator MOYNIHAN. No, it is not a travesty. That is a pattern that we have been trying to find social explanations for it for about a century and a half, and we have not gotten very far.

Ms. GRUENDEL. I would agree. My concern is that we do not have enough children to continue to throw away the generations that I am very afraid we are.

The second part of the time that I have I would like to talk very specifically about the Federal funding issues that you have in front of you and upon which you are deliberating.

Senator MOYNIHAN. Right.

Ms. GRUENDEL. The HHS budget for foster care and child welfare, while it marks a significant improvement over past years, for which we are enormously grateful, it does not adequately address the crisis that we face. In fact, the Administration's proposal to cap Title IV-E administrative costs will hurt the ability of States to protect and care for these most vulnerable children. Let me be specific.

The Administration has proposed to cap Title IV-E administrative costs beginning in fiscal year 1991. In the first year the Administration expects a "savings" for the Federal Government of about $161 million by taking this action. Importantly, what this means is that these costs will be transferred to the States. Just as an aside, this proposal also intends to take some of those savings and use them to boost the IV-B allocations. We are taking from Peter to pay Paul; we are not in favor of that.

The Administration has long been concerned about the rising administrative costs in the Title IV-E program and has tried unsuccessfully to cap these expenditures over the last 2 years—most recently last year, which was unsuccessful. The Administration makes two arguments to support this proposal that we cap this particular piece of Federal funding.

The first is that the States are "gaming" the system to increase their IV-E reimbursements. The second is that this increased spending has not resulted in an equal expansion in the quality or quantity of services to children.

This issue, Mr. Chairman, is extremely important for the States and I would like to take a few minutes to set the record straight with regard to these two allegations.

Senator MOYNIHAN. You take all the time you want.

Ms. GRUENDEL. Thank you. This is great. I cannot even get this kind of time at home. I hope they are listening.

First, HHS has never provided evidence to Congress that shows that the States are claiming Federal reimbursement for anything other than legitimate costs. The public record is absolutely clear. In fact, the HHS Office of the Inspector General issued a report in 1987 called "Foster Care Administration Costs," and it disputes its own Department's charge that the States have claimed illegally with regard to this reimbursement mechanism.

Let me tell you specifically what IV-E administrative costs are. As a bureaucrat, I am very sensitive to the charge that we pad our administrative budgets and that we sit at our desks and do nothing reasonable, and we bill the Federal Government for this. That is not true.

IV-E administrative costs provide for reimbursement for the following kinds of child welfare activities: Referral to service for children who must be removed from their home and preparation for and participation in judicial determinations. We have an obligation when we remove a child to prove to the court's satisfaction that the removal was appropriate, that we are taking adequate steps to return the child to his/her own home, and if we cannot do that we

are seeking a way to find the child a permanent home. This action is required under Federal law and it is a reimbursable Title IV-E administrative expense.

Title IV-E also allows us to be reimbursed for IV-E eligible children's placements in foster care. Most of which I would respectfully remind you are placements in foster family care—foster families where we, frankly, pay families less than about 50 cents an hour to take care of very difficult children. So we are expending a lot of money for placements.

Title IV-E allows States to be reimbursed for case reviews, which is a process whereby an independent group looks at the decisions that we make as professionals abound the lives of these children and families to assure that the decisions are in the best interest of the child, that we do not do sloppy work, and that we put the child first.

It allows States to provide case management and supervision. I do not know if any of you have ever had a child removed from your home. When that occurs it is very painful. It is extraordinarily traumatic for all parties. Someone needs to be hooked with that child. Someone needs to make sure that the child is getting the services that he/she needs and the parents into whose home you would like to return that child are getting the service they need. These are part of the administrative dollars changed to Title VI-E.

Senator MOYNIHAN. Can I just interrupt and make a personal observation—anecdotal, but then data is often said to be the plural of anecdote. Early one morning I stopped by a center in downtown Manhattan where children are brought by police and other people who are found on the streets and so forth the previous night, just to sort of see what was going on. I had with me a New York detective who in the best tradition of police who have to deal with the hard side of life, was not an overly sympathetic man. He did not go around weeping and gushing about the world. He took the world pretty much as it is.

We got back into the car and he slammed the door and started up the car and went roaring away. And said blank, blank. "I have seen better recordkeeping in a dog pound." So he found out what is going on with these children. And that is called the absence of administrative effort at a level you would expect.

Ms. GRUENDEL. I also—just to follow on your aside, which is probably not legal, but I will take the opening you gave me. I had the opportunity to deliver a talk in Baltimore about 3 weeks ago and arrived at the train station quite late at night and was picked up by a cab driver who asked me what I did. It is very hard to tell people what you do when you do what I do because first of all they do not really care and secondly, it is hard to explain—trying to save the lives of children.

And he asked me and I told him, and I think it provided an opening for him because we spent the 15 or 20 minute ride and he explained to me how he had been abused as a child and how he was trying not to do that with his own children. And it was a very heartwarming experience of a different nature than yours.

But I think there is great feeling and support out there for this issue in places that we might not suspect.

The last two things that Title IV administrative provisions allow States to do is to to seek reimbursement for the recruitment and the licensure of foster homes for children. There was a trend in the United States through about 1987 that we were making great strides in keeping children at home. Since 1987 more children are coming into care.

Senator MOYNIHAN. What happened?

Ms. GRUENDEL. I think that you hit on it in some important ways when you asked questions about substance abuse. It is not the only issue. Poverty is increasing, but substance abuse is a very major issue for children. That trend is on the increase. Although we try to develop and implement intensive preservation services to keep kids at home we are increasingly removing them.

Those children need a place to live. And Title IV allows us to get some reimbursement for the cost of finding those homes and supporting foster families. Importantly, you should know that in all adoptions in this country, 50 percent of them come from foster families. So we need to continue to be able to do this and do it well.

Lastly, Title IV-E allows States to claim rate setting as an administrative activity. Thus, it is simply not true, as the Administration has alleged, that administrative costs in Title IV-E are overhead costs and that they can simply be cut. That is not true.

A cap on administrative expenditures would hurt children. There is no way around this. It will undermine the ability of the States to carry out the mandates of P.L. 96-272. That is the law which was passed by this august body that requires that we do the right things for children whose parents cannot do them for them.

Senator MOYNIHAN. We like that—the august body—that is good.

Ms. GRUENDEL. I genuinely mean it. What we need now is the support to allow us to do what it is that you and we know that we need to do. Capping the system at a time when the State's child welfare systems are under extreme stress and have been dealing with cutbacks already simply means that there will be fewer dollars to provide the services that we need to provide to protect the lives of children. We are not talking about children that we want to make feel happy, although I would love to be able to tell you we are doing that. We are talking about children whose lives depend on our action.

The other reason for not capping Title IV-E is that it will penalize States who have not already been able to develop a system of claiming the legitimate expenditures that they have. Some States have moved ahead through the use of eligibility technicians, through much better data systems than some of the rest of us have, and have begun the process of claiming what is legitimate to claim under the law; many other States have not. So if we now cap the States who are just beginning to get those systems up they will be unable to claim reimbursement.

I would end the formal part of this testimony with an invitation to you, sir, on behalf of the rest of the States. The beeper that I carry works 24 hours a day. But unlike the beepers that may be on your belt or the belts of your staff members, mine is hooked up to Connecticut's child abuse hotline and 24-hour emergency service. My invitation to you, my challenge is very simple. Before you decide that we cannot as a nation afford to fully fund the critical

programs that prevent child abuse and neglect, that prevent dependency, that prevent out-of-home care, and that protect children whose very lives are at stake, before you do that, I would ask you to put a protective services worker on the other end of your beeper.

It occurred to me on my trip here that that would make a great catchy slogan. But I mean it, for a day or two. You need to experience what we do. You need to feel what we feel for kids. You need to feel what families are feeling. I think I could guarantee, humbly guarantee, that from that point on—that is, if you are attached to one of our beepers for even a day or two—it will never be possible again to make decisions without the face of a child and it will be possible to make the investment decisions that, frankly, I think we have no choice but to make.

I am profoundly honored to have the opportunity to sit here before you. I believe very deeply in the work that we need to do for children and I thank you.

[The prepared statement of Ms. Gruendel appears in the appendix.]

Senator MOYNIHAN. We thank you, Ms. Gruendel. It is very clear that we are—there was, if you like, a discontinuity in the 1980's, that we had certain trends going pretty steadily in the direction of more children. About a third of the children in the United States born this year or last year will be on welfare, on AFDC, before they are 18. That means they are paupers by definition. They are paupers.

No industrial society in the world has anything like this. Canada would not know what we are talking about. But simultaneously, you have the discontinuity of two epidemics.

Ms. GRUENDEL. That is right.

Senator MOYNIHAN. And we do not fully recognize them as epidemics. We are not good at epidemics anymore. We used to be because we had, you know—an influenza hit, you had a lot of people die. But we have not absorbed that information and certainly the Administration has not. You have. You live with it.

I recognize that you were here, of course, not just representing yourself, you are representing the American Public Welfare Association. We appreciate your testimony very much. We thank you.

I have a question Senator Bentsen would like to address to you. I will give it to you in writing and perhaps you would give us a response.

[The question appears in the appendix.]

Senator MOYNIHAN. I think you will find that this committee is with you. The Administration obviously is not.

Senator Rockefeller?

Senator ROCKEFELLER. No questions, Mr. Chairman.

Senator MOYNIHAN. We thank you very much indeed.

Ms. GRUENDEL. Thank you very much.

Senator MOYNIHAN. It was very impressive testimony.

Mr. Chairman, I turn the gavel over to you, sir, as we go through our segmented day.

Senator ROCKEFELLER. Our fifth panel, Dr. Ring, Dr. Ebert, Dr. Czarsty, and Dr. Lichtenfeld if you all would come forward. Jeremy Jones, also, if you could come forward. There is no reason, I think, to split these panels.

Dr. Ring, we would start with you, sir.

STATEMENT OF JOHN J. RING, M.D., CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, MUNDELEIN, IL, ACCOMPANIED BY ROSS RUBIN, DIVISION OF LEGISLATIVE ACTIVITIES

Dr. RING. Thank you, Mr. Chairman. My name is John J. Ring, M.D., and I practice family medicine in Mundelein, IL. I am also chairman of the board of the American Medical Association. With me today is Ross Rubin of our division of legislative activities.

Mr. Chairman, we have provided your staff with some additional materials which we request be included in the record.

Senator ROCKEFELLER. And they will be.

Dr. RING. Thank you.

[The information appears in the appendix.]

Dr. RING. I have addressed several important issues in my written testimony—the proposed Medicare cuts, physician billing limits, Medicaid expansion, the effect of Congress' treatment of student loans on access to care and the pending CLIA regulations.

Although I will limit my comments to the Administration's proposed Medicare cuts, I call your attention to the written statement which details our concerns regarding all of these issues.

The AMA recognizes the necessity for the Congress to work to achieve the goal of a balanced Federal budget and to meet reconciliation targets assigned by budget resolutions. We know that this committee has made and will continue to make those tough decisions about numerous programs.

As you well know, the Medicare program has presented you with many difficult decisions over the years, and has suffered massive cuts since the inception and continued use of reconciliation during the decade of the 1980's. This committee in its recent statement of "Views and Estimates" regarding the fiscal year 1991 budget acknowledged the beleaguered status of Medicare. We have studied that statement and thoroughly agree with you.

The Administration's proposed fiscal year 1991 cuts, which come in the wake of the sweeping physician payment reforms enacted only 3 months ago, are not a solution to the high costs of health care. Rather, they are the result of arbitrary attempts to find savings no matter how great the cost. This approach threatens to undermine the physician payment reforms of OBRA-89, jeopardize the availability of quality health care for Medicare beneficiaries and overwhelm a physician community that is attempting to practice medicine while accommodating the massive payment and practice reforms just adopted.

As a result of the increasing constraints imposed on physicians in the past decade, the practice of medicine as we know it is starting to disappear. Physicians are abandoning self-employment for salaried positions, positions that spare them the burdens of start-up costs and office administration, and the long hours associated with private practice. This trend is especially disturbing for the underserved sector of this country, nearly three-fourths of which is comprised of rural areas.

Some physicians are forfeiting the practice of medicine altogether, and young Americans are rejecting medicine as a career choice. Medical school applications have decreased 25 percent over the past 5 years. Physicians' concerns about professional liability issues and six figure liability premiums go ignored, and Medicare rewrites the rule book every year.

What is the relevance of all of this to the budget process? As I stated earlier, it is not to say that bringing the Federal budget into balance is unnecessary or impossible. It is, however, the very relevant backdrop for your deliberations.

Mr. Chairman, the Administration's proposed savings should be rejected for three reasons. First, the Medicare program has been subjected to over a decade of major funding cuts. Additional cuts in fiscal year 1991 will only exacerbate the inequity of Medicare shouldering such a massive share of Federal budget cuts.

Second, Part B has historically borne a disproportionate share of Medicare cuts. The reality is that Part B has been subjected to significant cuts in the form of freezes and budget reductions, which are detailed in my written testimony.

Third, the Administration's proposed cuts will undermine the payment reforms of OBRA-89. Just 3 months ago, Congress enacted dual landmark physician payment reforms—the Resource Based Relative Value Sscale (RBRVS) and the Medicare Volume Performance Standards (MVPS). The RBRVS methodology is the result of years of research and evaluation, and is designed to ameliorate the reimbursement inequities of the reasonable charge system.

Implementation of RBRVS will have significant effects of transferring resources between medical specialties and geographic regions of the United States. Congress crafted a 5-year transition period to reduce any dislocations that these resource shifts might cause. In addition, although RVRBS is methodologically sound, it has not been implemented in any major setting. Therefore, caution is necessary so that we can understand the impact of RBRVS implementation and correct problems that arise during the transition period.

The budget cuts destroy the concept of budget neutrality upon which RBRVS is premised by chipping away at the payment levels in effect when Congress enacted the fee schedule. Consequently, the fundamental goal of RBRVS—redistribution of resources—will be subverted; there simply will not be adequate funds available to transfer from one specialty or region to another to compensate adequately undervalued services or regions.

In conclusion, Mr. Chairman, Medicare has been subjected to years of significant budget cuts, and we have recently attained massive reforms in physician payment. Although we do not believe that RBRVS is a panacea for all physician payment issues, it is a well-grounded effort at achieving equity in reimbursement. We urge you to prevent the undermining of RBRVS, and to protect the program from further cuts that, if imposed, will jeopardize the health care of the nation's elderly and disabled.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Dr. Ring.

Dr. Ebert?

STATEMENT OF PAUL A. EBERT, M.D., F.A.C.S., DIRECTOR, AMERICAN COLLEGE OF SURGEONS, CHICAGO, IL

Dr. EBERT. Mr. Chairman, I won't take much time except to emphasize a few of the points that are specific for surgery, as well as to echo Dr. Ring's comments. We believe the ink is barely dry on the new physician payment reform plan. We believe the phase-in time is very realistic. Yet, we are very concerned that there are individual citings made this year in the President's budget that have very little logic or definition. We have a hard time understanding across the board why MEI updates are proposed only for primary care. We have a lot of undervalued procedures in surgery as well as some that are considered overvalued.

The issue of overvalued procedures continues to come up again. But it is at its peak. It has been up for several years before. Payment for these procedures and operations has been reduced in the past, and it seems rather strange that they constantly reappear on the list even though the RBRVS, per se, has not been completed for all of these procedures. So it is a very optional type of targeting so to speak.

Two areas concern us the most, and seem to be the poorest defined and probably the most illogical. The first is the attack on the global surgical fees. The program to reduce hospitalizations is very positive from the hospital standpoint by reducing the length of stay. On the other hand, the amount of work effort put into the global care of that patient does not depend on whether it is done in the hospital or at the doctor's office after the patient is discharged.

Most surgeons would say that early discharge has probably increased their time and effort because they have to see these patients more frequently in their office. Sometimes there is more inconvenience to the patient and to the surgeon. The 1 or 2 days saved by the hospitalization may benefit the hospital in the total of a program, but it certainly does not mean it is less work and effort. So to reduce global surgical fees based only on hospitalization seems to be a very poor approach.

I think the assistant at surgery proposal is also flawed. The College in its proposal several years ago and in its statement on principals has always stated that an assistant at surgery should be the most qualified person available, and it should be an assistant that was present at the request of the surgeon. The surgeon should be the person who decides whether or not they need an assistant. We do not see how reducing the fee paid for an assistant—whether it is a surgeon, non-surgeon or whatever type of person happens to be present—we cannot see where that is beneficial for the quality of care for the patient.

We are very concerned that many surgeons, if the reimbursement is cut below the 20-percent level down to 12 percent, are going to find it is not practical to be an assistant. They would prefer to do office practice or something else. So I think that when an assistant is needed, we would like the patient to have the benefit of the best quality individual that is present, who should be reimbursed and compensated for that service.

We recognize very much that you do have budgetary constraints and you have problems with the program. No one likes to propose

any type of budgetary reduction for a program such as Medicare when it is probably underfunded and in difficult times as it is. But it does seem to us that if it has to be done and there has to be reductions it would be more logical to do it across the board on some type of sequestration type of approach and let the physician payment reform legislation that has recently been passed have a chance to have an effect.

I think you very much for the opportunity.

Senator ROCKEFELLER. Thank you, Dr. Ebert.

[The prepared statement of Dr. Ebert appears in the appendix.]

Senator ROCKEFELLER. Dr. Czarsty?

STATEMENT OF JOSEPH C. CZARSTY, M.D., CHAIRMAN OF THE BOARD, AMERICAN ACADEMY OF FAMILY PHYSICIANS, OAKVILLE, CT

Dr. CZARSTY. Thank you, sir. I am Dr. Joseph Czarsty, chairman of the board of the American Academy of Family Physicians, representing over 68,000 practicing family physicians, residents and medical students. Thank you for inviting me to share with you our Academy's views regarding Medicare budget proposals.

First, I would like to thank the members of this committee for your fine work during the first session of Congress to enact Medicare physician payment reform. The Academy believes that the new law holds the potential for providing greater equity in payments to physicians, financial protection for beneficiaries, a measure of control and a growth of Medicare expenditures, and support for improving the knowledge base on which clinical decisions are made.

However, in order for the benefits of the reform to be realized, the transition to, and the implementation of these four elements must be carefully managed. We encourage you to monitor this process to ensure that implementation is done in a manner consistent with congressional intent and within the time frame specified in law.

We, therefore, caution against further changes in Medicare physician payment that could alter the progress made to date. Any modifications in the program to be consistent with, and move in the direction of the reformed package, and assist rather than hinder the transition. One proposal that would be positive from this standpoint would be the increase in the MEI for primary care services. However, many of the other proposals included in the Administration's budget give us great concern. I will briefly outline these in the next few minutes.

The proposed reduction in payments for overvalued procedures violates the spirit of physician payment reform by failing to address undervalued services. The method has not been successful in slowing the growth in Medicare spending to date and there is little reason to expect that it will achieve the intended effect in fiscal year 1991.

We have similar concerns about the proposed reductions in payments for procedures in overvalued localities. This proposal fails to address the perversely low payments in other mostly rural areas and perpetuates the access problem faced by rural beneficiaries

while offering little hope of effectively addressing the growth and volume.

The proposal to limit payment to new physicians for 5 years also is contrary to one of the purposes for developing the fee schedule—that is to rationalize payment. Once an appropriate fee for each service is set we believe it imperative that Medicare recognize the fee for all physicians providing the service, regardless of the number of years they have been in practice.

Another proposal calls for paying the same amount for a surgical procedure regardless of whether or not the primary surgeon elects to use an assistant—that is with limited exceptions. We are concerned that the proposal would create a disincentive for a physician to provide assistance at surgery and encourage surgeons to select assistants from the hospital staff in order to keep the entire fee. Individual situations often require that there be another physician actively participating in the patient's surgical care and family physicians are particularly qualified to provide this assistance because of their knowledge of their patient's medical history.

With respect to clinical laboratory services, the Administration proposes a savings of $60 million by reducing the fee paid for lab services. This comes at a time when stringent regulatory requirements for previously unregulated labs are being developed, requirements that are anticipated to create considerable additional costs for physicians' office laboratories. These costs, coupled with fee reductions, could create significant hardships, ultimately diminishing the number of laboratories and threatening patient access to quality laboratory services.

I would like to change the focus from Medicare physician payment for a moment to briefly discuss the Medicaid program, specifically as it relates to access to care. The Academy is increasingly concerned about the lack of access to care by millions of uninsured children and adults. We support efforts of the Physician Payment Review Commission to examine the Medicaid program and we look forward to working with Congress to develop a plan using Medicaid as one component of providing access to insurance for all our citizens.

Budget proposals affecting hospitals, particularly rural hospitals and teaching hospitals, are also of concern to family physicians. The failure of Medicare to pay its full share of capital costs in rural hospitals places an additional burden on these facilities which typically are already experiencing negative margins on their Medicare business. The proposed reduction in payment for certain hospital outpatient services will also disproportionately affect rural hospitals.

The changes in Medicare graduate medical education payments, both direct and indirect, may have a negative impact on ambulatory based residency programs, such as family practice. As reductions in Medicare payments to hospitals cause them to evaluate their commitment to medical education, family practice programs may seem less attractive.

In summary, we urge the committee to reject Medicare budget proposals that would disrupt the positive action taken by Congress to reform Medicare physician payment. We further caution against

additional reductions in Medicare payment to hospitals that would jeopardize primary care education and impede access to care.

Thank you, sir.

[The prepared statement of Dr. Czarsty appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, Dr. Czarsty.

Dr. Lichtenfeld?

STATEMENT OF LEONARD LICHTENFELD, M.D., PRESIDENT-ELECT, MARYLAND SOCIETY OF INTERNAL MEDICINE, TESTIFYING ON BEHALF OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE, BALTIMORE, MD

Dr. LICHTENFELD. Thank you, Mr. Chairman. My name is Dr. Leonard Lichtenfeld, and I am an internist from Baltimore, Maryland. I am pleased to share with you the views of the American Society of Internal Medicine on proposed budget and policy initiatives relating to the Medicare program.

ASIM appreciates the work done by the members of this committee in developing last year's historic consensus for physician payment reform. But this is not the time for you or for us to be complacent with what has been accomplished. If the Administration has its way, the long-term benefits of physician payment reform will be sacrificed in order to attain immediate fiscal year 1991 budget savings.

The budget borrows the language of reform while working to undermine it. Instead of improving equity, further cuts will detract from the ability of the new Medicare fee schedule to correct the inequities that now threaten access to primary care services, particularly in rural areas.

Since 1991 is the base year for determining a budget neutral conversion factor for the new Medicare fee schedule, the proposed cuts would require that the conversion factor be set at a proportionately lower level in order to maintain budget neutrality. In that case, everyone loses.

Rural communities will be dismayed to find that the new fee schedule does not provide sufficient incentives to attract and maintain primary care physicians. Physicians who hope that their primary care services will be paid more fairly will feel betrayed when they realize that more cuts, but few or no increases, are in store. It makes no sense for Congress to enact major reforms in physician payment only to let those reforms be circumvented through the budget process.

Internists are also concerned that continued cuts in Medicare will inevitably compromise availability and quality of medical care. There is growing evidence that low levels of reimbursement, coupled with the growing administrative burdens or hassle factors associated with the Medicare program may be beginning to harm access.

A recent survey of internists found that growing disillusionment with medical practice is leading established physicians toward early retirement and discouraging new physicians from entering primary care. The authors of the survey argue that "If withdrawal from practice combines with the inability to attract medical stu-

dents into the field, it is not difficult to construct a scenario in which physicians in practice will be difficult to find."

The RBRVS fee schedule offers the promise of reversing some of the pessimism that may be discouraging physicians from entering primary care. But if Congress agrees now to cuts that diminish the proposed gains for reimbursement for primary care, the scenario of reduced access to primary care services may be at closer hand than many of us would like to believe.

We urge the committee not to be taken in by the Administration's reform rhetoric and to reject cuts in Medicare Part B that will undermine the RBRVS fee schedule. ASIM also strongly urges the Finance Committee to oversee how the dollar conversion factor used to create the new fee schedule is developed by HHS. The Administration has signaled its intent to assume a major increase in the volume of services under the new fee schedule in order to justify a much lower dollar conversion factor.

This would violate Congress' intent that payments for undervalued services be substantially increased. Unexpected changes in physician behavior should be factored into the conversion factor only if there is hard evidence, based on actual trends and utilization following the initial phase-in of the RBRVS fee schedule to justify such an offset.

ASIM also believes that Congress should reject any recommendation from HHS for separate Medicare volume performance standards and fee updates by category of services. Separate standards and updates will undermine the RBRVS and lead the fragmentation of effort within the medical profession, rather than a unified approach to controlling volume.

We urge the committee to address the problems being created by the widespread down coding of evaluation and management services by Medicare carriers. Mandating a fee schedule that pays more for each level of service does no good if the Medicare program can simply offset those increases by routinely downcoding those services to a lower level of care.

Finally, the issue of reducing the administrative burdens placed on physicians by the Medicare program should be on the Finance Committee's agenda for ongoing consideration. Growing physician disillusionment with the Medicare program threatens future access to primary care services. Congress should act now to restore some reason and rationality to Medicare's administrative demands, rather than waiting until a crisis develops.

I appreciate having the opportunity to address the committee. I would be happy to answer any questions.

[The prepared statement of Dr. Lichtenfeld appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Lichtenfeld. I will have a few.

Mr. Jones, why don't you go ahead?

STATEMENT OF JEREMY M. JONES, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HOMEDCO, INC., TESTIFYING ON BEHALF OF THE HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION AND NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, ORANGE, CA

Mr. JONES. Thank you, Mr. Chairman. My name is Jerry Jones. I am President of Homedco, Incorporated in Fountain Valley, CA.

Over the past few months I have had an opportunity to work with members of the Senate Finance Committee staff and I am pleased by their willingness to learn more about the home medical equipment business. Homedco is a home medical equipment supplier that operates in 30 States and we have 130 locations. We are in the infusion, the respiratory care, and the home medical equipment business.

I am here today representing the two trade associations that represent our industry—the Health Industry Distributors Association and the National Association of Medical Equipment Suppliers.

Before I proceed, I would like to talk specifically about who makes up our industry. Our industry is made up, substantially, of providers of all types of health care services—hospitals, major organizations—such as the Voluntary Hospital Association in Dallas; primary acute care facilities—such as the Cleveland Clinic and the Baylor Medical Center—all have vested interests in the home medical equipment business. That is also true of the Visiting Nurse Association in major markets, such as New York City, Dallas, and Los Angeles.

In addition to those major entities there are 2,000 to 3,000 independent business people who are operating in a variety of different markets and there are also a few limited number of national firms, such as Homedco, that participate in this business.

I think it is important for you to understand how we acquire our business. The home medical equipment industry is a referral business. We generally rely upon recommendations from medical professionals, such as physicians and hospital discharge planners, to refer patients to us for the services that we supply, on an ongoing basis. We, very infrequently, market directly to patient users.

The fiscal year 1991 Medicare proposals from the Administration proposes a $5.5 billion cut which represents better than 33.3 percent of the total expenditure cuts proposed by the Administration. The Medicare portion of the Federal budget is only 8.3 percent in total. It seems to be substantially out of line.

We were pleased recently to see that the Senate Finance Committee had endorsed to the Budget Committee that the sequestration level appears to be an appropriate level for fiscal year 1991.

With regards to the home medical equipment business in particular, the Administration has proposed cuts of $250 million. The home medical equipment business is 1 percent of total Medicare expenditures. And the Administration is asking us to assume 6 percent of the total cuts overall. I do not believe that it is fair to a service component that (1) is perceived as being cost effective; (2) that is one of the few true long-term care benefits that exists for 65 year old beneficiaries and (3) for an industry that is struggling to keep up with continuous and on-going cost containments.

If you were to review the legislative history of our industry, you would find out that we have experienced a continuation of freezes and updates since 1985. Over a 7-year period we have had a 1.7-percent CPI increase. During that same period of time costs based upon CPI have increased at better than a 20-percent level.

The administration's proposal that we have been talking at great length about is the proposal to develop a national fee cap structure for reimbursement of home medical equipment products. To begin with, this destroys the six-point plan methodology that was passed as part of the reconciliation program in 1987 and was implemented in 1989. The six-point plan architecture calls for regional rate reduction over the period of 1991 and 1992.

The HME business—the home medical equipment business—is primarily a local business that is service intensive and people intensive as well. Our cost factors are driven almost totally by local factors—the geographic market that we serve, the wages, insurance, and the State and local regulations under which we operate. We are a highly regulated industry in that we have to comply with both the Department of Transportation regulations and the FDA.

To cite a couple of examples of the type of independent regulations under which we operate. In the State of Washington, home medical equipment services are taxed—sales tax is at a 7-percent level. In the States of Maine, Ohio and Texas, there are individual regulations that require certain clinical standards and qualifications for providers of home medical equipment services that do in fact deal with patients.

National rates do not reflect variations in local markets, either by medical practitioners, by State regulation, or the local costs of doing business.

In our written presentation, I have addressed other areas that were proposed by the Administration, particularly the reduction in payment structure from 150 percent of purchase price to 120 percent; and also a proposed additional reduction of 5 percent on oxygen. We are opposed to these initiatives in that we have already accepted a 5 to 30-percent reduction of oxygen during the last 12 months.

In addition to that I am aware that the Senate Finance Committee has interest in the competitive bidding approach to home medical equipment and I would be prepared to deal with that question sometime in the future should it be appropriate.

In summary, I guess I would like to tell you that our industry is definitely opposed to the Administration's proposal. We believe that the cuts should be proportional and that we represent 1 percent of the business. I would also suggest that the private sector has developed means of controlling utilization and putting incentives in the proper place to reduce overall expenditures.

Mr. Chairman, I thank you for your time. I would look forward to answering any questions, either in written form or orally, should you require them.

[The prepared statement of Mr. Jones appears in the appendix.]

Senator ROCKEFELLER. Thank you, Mr. Jones. I will just pick up your invitation about competitive bidding. You said you would be prepared to address that at some future time. We are now 30 sec-

onds after you have made the statement. I am interested in your approach to it.

Mr. JONES. Mr. Chairman, competitive bidding is not necessarily a new concept. It is a concept that has been discussed in the past and has previously been tried. In fact, it was even analyzed by the Health Care Finance Administration and it has also been utilized in certain States. It has been difficult to manage at best.

And the reason for that is by and large to successfully bid services in the home medical equipment business, you need to break up the service areas throughout the United States and match them with product providers of each one of the individual equipment items that we supply. There are not suppliers available in our industry which traditionally handle a broad range of services. So to designate a specific geographic area where a single supplier could handle say 65 or 70 percent of all the services required would be very difficult to do at best.

In addition, the industry has difficulties in dealing with this approach. We are an industry that if we do everything right we probably can collect our accounts receivable in about a 90 day period of time. The availability of working capital to fund large increases in business through the attainment of a contract would be difficult at best. In fact, it might even give an advantage to some of the larger suppliers over the smaller companies in our business.

I guess I would like to cite the recent information that has been revealed by the Veterans Administration. For sometime the Veterans Administration has been using competitive bidding for obtaining oxygen service. Recently 11 of the major hospitals in the Southeastern portion of the United States went through the JCAHO accreditation process and all of them turned up with a deficiency in their home care service area because none of the suppliers who were servicing those areas even came close to meeting JCAHO standards.

In fact, in one particular situation it was reported that there was a single employee in the entire State of Alabama that was responsible for taking care of 250 individual oxygen patients.

In general, it is a very, very difficult thing to manage. From an administrative standpoint, not only for our industry, but certainly for the health care finance administration as well, it is a risky strategy because there is a likelihood that rural areas and certain beneficiary services that have been supplied in the past will become difficult to obtain in the future.

If, however, the Senate Finance Committee feels that it is a strategy that must be attempted and tried, I guess that I would ask that you work with our industry in addition to working with HCFA and let us have a substantial amount of input into the development of the system.

We also believe, because of the vulnerability of the system as it exists today, that the demonstration project would have to be of an extensive period, probably a minimum of 3 years. You cannot evaluate the impact upon beneficiaries and the success of the companies in managing the working capital deficiencies that occur without a thorough evaluation overall.

The other thing I would suggest to you is that beneficiaries will be impacted in a competitive bidding environment and that you

should take into consideration that beneficiaries should have some options to at least pay for additional services out of their own pocket should they feel it appropriate to do so.

We believe that competitive bidding is difficult. It is something that has not proven to be successful on a mass basis in the majority of situations where it has been tried in the past.

Senator ROCKEFELLER. All right. That is a full answer.

Mr. JONES. Thank you.

Senator ROCKEFELLER. And fair enough in terms of working with you all if that should come about.

Dr. Ring, I mean if there is anything that anybody knows is that there is a budget crisis and there is nobody more angry at the $5 billion, plus Medicare cut than myself. But we have to deal in the world as it is. I mean, the President What was lithe cut $3 billion from his defense budget of $300 billion and over $5 billion from the Medicare budget of $100 billion. That is not exactly what I call proper priority setting.

It is interesting, nevertheless, that, in the attachments to your testimony, the American Medical Association opposes every single budget cut in the President's budget except that you support raising beneficiary premiums, and you support ending payments to hospitals for certain payments to physician's assistants, a group of providers for whom you opposed payment in the first place. I would simply ask you, sir, within this context if that is an honestly balanced proposal that you have given to us.

Dr. RING. We think that increasing premiums to patients is a method of increasing patients' awareness that medical care is costly. It is my personal view that the hyperinflation in medical care, as opposed to other items in the general economy, is driven by excessive demand and a perception that health care is either cheap or free. I think the AMA's position on increasing beneficiary participation is to increase beneficiary awareness that medical care is not only valuable but also expensive.

With regard to the other providers that was to avoid a duplication I believe.

Senator ROCKEFELLER. To avoid duplication? Could you elaborate on that?

Dr. RING. I couldn't, but Mr. Ruben can.

Senator ROCKEFELLER. All right.

Mr. RUBIN. As we understand the Administration's rationale, Senator, hospitals were receiving as part of their DRG payment the cost of having those employees on their payroll. When that was then shifted over to direct cost it created a situation where there was direct reimbursement for the services of the PTA as well as that cost not having been adjusted into the prospective payment amount.

Senator ROCKEFELLER. Dr. Ring, do you have, in view of your testimony, do you have proposals as to how, in fact, the Medicare budget the extent that the Finance Committee will have to cut it to some degree how we should do so?

Dr. RING. I believe and agree with other speakers on the topic that if cuts must be made they should be made uniformly across the board.

Senator ROCKEFELLER. You mean Gramm-Rudman?

Dr. RING. The Graham-Rudman would be acceptable to us, if we came to that.

Senator ROCKEFELLER. But if one follows that philosophy, that you make cuts across the board, that is not decisionmaking, that is sort of nondecision making. I mean there are some things that are more important than other things and ultimately that is what policy is all about—making those choices. If you just say everything should be cut equally, in an era of financial trauma in medicine, isn't that too easy an answer?

Dr. RING. It may be too easy an answer. The AMA does feel that we have now reached the point where the Medicare budget cuts are hurting beneficiaries. I think Medicare has sustained too many hits over too many years, and that our patients are getting hurt. And if cuts are to be made, they should be made uniformly, rather than directed at specific targets such as our Medicare patients.

Senator ROCKEFELLER. I see.

Dr. Lichtenfeld, you suggested that the committee should consider providing a greater than inflation update for primary care services starting in 1991. That is interesting. I hope that you understand that there has been an enormous amount of sympathy on this committee, from this Senator and others, for physicians who provide primary care services. I assume that you know that we reported a physician payment reform bill last year that had a bonus payment of 10 percent, effective immediately, and that is not an inconsequential. That was for underserved rural and urban areas. That is law.

You know, I understand. Everybody has to fight for their position, but isn't that a bit much? We are talking—you do not disagree that we are going to have to cut Medicare as distasteful as it is to every one of us?

Dr. LICHTENFELD. Senator, I am going to step back for a moment and say that Medicare—I would agree with the proposition that Medicare over the course of years has taken, as has been said a moment ago, an enormous hit with respect to restriction of funds, to the point that basic medical care—the type of care that I have to deliver one-on-one with my patients may begin to suffer.

I think the hits have been enough. Now I am not disputing the fact that there are difficult decisions that are going to have to be made. I have to speak from my position as a primary care internist, recognizing the crisis that is occurring, that is coming about, as a result of what has happened over time. I certainly understand and appreciate, as does my organization—the American Society of Internal Medicine—the efforts that you personally have made as well as the members of the committee with respect to RBRVS.

But we face a real crisis in internal medicine. It is not an imagined crisis. The numbers are available. They are on the table. They are reported in reputable medical journals—the New England Journal. They have been reported in the public press recently in the New York Times. We face a rapid decline in graduate medical students entering the field of internal medicine because of a variety of perceptions and because of a—I would use the word—significant inequity in reimbursement.

How the committee chooses to address that issue is ultimately in the hands of you and your colleagues. I do not think, to argue the

position, that our situation has to be recognized is inappropriate. I do understand the difficulty that is faced in trying to come to a reasonable answer to a very, very difficult situation.

I think that you, yourself, alluded where the money is cut does not make sense. What I am saying here is that we have worked very hard on reform. The physicians have worked hard; the Congress has worked hard; the PPRC has worked hard, to come to a position where we are today where we are ready to move forward with meaningful substantive reform. It is time to do that. What is going on here may seriously jeopardize that reform next year and the year after.

Senator ROCKEFELLER. I think that is a very fair response. What in a sense you are all saying is that your professions are in danger—and also, Mr. Jones, you in a different way. There is a feeling out there that the reward, not just financial but psychic, for being in medicine is declining and we have an era of mistrust—every patient looking at you as a potential—you looking at them as a potential litigant, et cetera. In other words, a part of the service sense is gone.

Not all of that is money; and on the other hand, part of it is. That is the point of RBRVS, to shift rewards towards primary care. I cannot argue that. It does not make much sense to talk about what are we going to do to rural hospitals and updates and closing the differentials. If people aren't getting into the profession, and if the very best of our people are not getting into the profession, money has to be a part of that.

There are a lot of places, it seems to me, including in my own State, where people think that kids go to school and if there is a teacher there that is fine. But what is important is that to get the very best teacher, you have to pay people to teach; you have to reimburse physicians to practice. But there are other aspects as well: this general malaise of budget deficit out of control, this new relationship between patients and doctors which is exacerbated by medical liability—your requirements to practice defensive medicine which is distasteful to you—sort of a departure from the original comfort of that relationship.

Don't these aspects have to be addressed by much larger mechanisms than we are talking about today? I would point right to the Pepper Commission and some of its recommendations. I agree with you, Dr. Ring, I think that people do have to pay their part of the cost of health care in order to understand that overuse or abuse of the system, is not in their financial interest. The way that they are going to understand that is by having to pay for part of it. And you have to address such things as universal access.

I mean part of the financial burden is, in fact, uncompensated care, not only to hospitals but to doctors and very much in the kinds of rural areas that I represent. In rural West Virginia a family physician does not make $400,000 or $500,000, but may in fact make $40,000 or $50,000. It would depend upon the area.

So I mean really we are tinkering here, aren't we? There is a demand for much larger answers, much more fundamental answers in public health policy. Is that not fair?

Dr. RING. I think so, Mr. Chairman. I think that is one of the reasons we at the American Medical Association supported the

Pepper Commission report. But when you get into the broader more philosophic aspects of the issue, that is really our profession's job. In every doctor there is a little bit of altruistic missionary, a little bit of militant professional, a little bit of businessman, and a little bit of what I hope is just temptation, but of a money grubber.

The challenge to our profession is to see to it that we stick to the bases upon which our art rests. Those bases are competence, ethics and compassion. If we lose them, as a profession we lose, and more importantly, our patients lose an awful lot.

I think that in spite of all the "hassle factor" that we have heard about, there is an awful lot good about medicine. And it is up to us as professional leaders to see to it that it stays there.

Senator ROCKEFELLER. I think that is really well said. I think it is a really honest statement that you have made too. Because you are describing a physician in the way that you would describe any person in this country. In other words, a doctor does not have to be in the business of medicine for 100 percent altruistic reasons in order to be called a good doctor or a good person. There has to be that mix as there does on all the rest of us. Those of us in public service are underpaid, we feel. But our constituents certainly do not. So there has to be a mix. I think that point is a very fair one.

I don't really mean to be waxing philosophical here. But I do worry enormously. In West Virginia we get help from the National Health Service Corps which I strongly support because it is a little bit like the way I got to West Virginia myself as a Vista volunteer. I decided to stay because I went there for altruistic reasons and fell in love with the State, and that was 26 years ago.

Well as you know, in the National Health Service Corps, doctors go to a place and then they get intrigued by it and sometimes they stay there. But the National Health Service Corps cannot do it all. I mean that is just sort of trying to fill in the regular demand and supply problem that you are referring to. We also have to address reimbursement; we have to face up to medical liability, as in fact I think we have to face up to product liability in order to make ourselves more competitive on a manufacturing basis.

Medical liability is absolutely fundamental. We had a situation recently in West Virginia—and I will not comment on the merits of the case because I am not qualified to—but the jury awarded a $15 million settlement on a case and immediately the next day the County announced that its hospital would no longer deliver babies. We have 92 OB/GYNs left in West Virginia. Two years ago there were 200. One-half of those are 5 years from retirement; and I guarantee you they will all take it.

The pediatrician that brought up my wife's and my four children is just a superb pediatrician. He just said 6 or 7 years ago, "The hell with it. I have had it and I am getting out." And he did. He went to Florida and is doing other things.

We have to understand there is an instinct in this country to blame doctors for making money or to be angry at doctors for making money. That causes people to be hostile in some cases. On the other hand, you cannot go through the training that you go through and accumulate the debts that you accumulate and then have us expect you to go out into rural areas or inter city areas without being compensated.

I really think it is a dilemma. We have to make fundamental changes in our system. We have to adopt a public posture from policymakers that says to professional medical people that you are valued as human beings as well as professionals, and that we are not at some kind of war. In a sense, we are all trying to accomplish the same purpose, which is to get health care to people who need it, which we are failing to do in this country.

That was not a question. There will be questions of Senator Bentsen, and others will have to submit to you in writing.

[The questions appear in the appendix.]

Senator ROCKEFELLER. I thank you all very much for listening to my meandering thoughts.

This hearing is adjourned.

[Whereupon, the hearing was adjourned at 1:02 p.m.]

APPENDIX

Additional Material Submitted

Prepared Statement of Senator Lloyd Bentsen

Today's hearing is an opportunity for the Committee to hear comments on the spending cut and policy changes proposed in the Administration's 1991 budget pertaining to Medicare, Medicaid, foster care, and other income security and social service programs that come under the jurisdiction of this Committee.

The Congressional Budget Office estimates that the Administration's budget proposals would lower payments for services under the Medicare program by about $5.2 billion. This is the single largest spending reduction proposed in the President's budget. Of the total, $3.9 billion—75 percent—would come from reducing payments to hospitals for inpatient and outpatient services. Abut $990 million, or 19 percent of the cuts, would come from payments to physicians.

In my view, cuts of this size are excessive. Hospitals would be the principle source of the savings. Yet the Prospective Payment Assessment Commission tells us that half of the hospitals across the United States lost money on Medicare patients in 1987, and that the situation has deteriorated since then. Some of the proposals, such as reducing the indirect medical education adjustment from 7.7 percent to 4.05 percent, have previously been rejected by this Committee. With regard to physician payments, the Physician Payment Review Commission suggests that many of the Administration's proposals would interfere with implementation of the payment reform package that was recently enacted.

Now, while I do not believe that this Committee can accept the Administration's proposed $5.2 billion in Medicare speeding cuts, we undoubtedly will have to take steps to reduce growth in Medicare expenditures, which increased 35 percent between 1985 and 1989, more than twice the increase in the Consumer Price Index. Hopefully, our witnesses will give us some guidance about which proposals will help us make necessary cuts in a way that is least disruptive to good patient care.

We'll also be looking for guidance on the issue of Federal funding for foster care placement and administrative activities under the Title 4-E program. Ms. Janice Gruendel, Deputy Commissioner, Connecticut Department of Children and Youth Services, will present the views of the American Public Welfare Association on the Administration's proposal to impose a 10 percent limit on annual increases in Federal matching for costs incurred by the States for foster care placement and administration.

In addition to those witnesses who requested the opportunity to appear today, we will be hearing from the two Commissions charged with advising us on Medicare payment policy. Dr. Phil Lee, Chairman of the Physician Payment Review Commission agreed to join us today. Although the PPRC annual report is not due until April 1st, Dr. Lee is here to discuss PPRC's reaction to the proposals in the President's budget affecting payments to physicians. Dr. Bruce Vladeck, President of the United Hospital Fund of New York, and a member of the Prospective Payment Assessment Commission, will report to us on ProPAC's annual recommendations for changes in Medicare's prospective payment system for hospitals.

I'm sure today's hearing will be helpful to the Committee as we begin our deliberations on the 1991 budget.

Prepared Statement of Joseph Czarsty

I am Joseph Czarsty, M.D., Chairman of the Board of Directors of the American Academy of Family Physicians, the national medical specialty society representing

over 68,000 practicing family physicians, family practice residents and medical students. Thank you for inviting me to share with you today our Academy's views regarding the Medicare program.

I would first like to thank the members of this committee for your exemplary work during the final hours of the first session of the 101st Congress to accomplish passage of Medicare physician payment reform. The package that you and your colleagues in the House enacted represents a thoughtful approach to addressing many of the concerns that Congress, the medical profession and the public have shared about the Medicare program. You in Congress designed a comprehensive reform package, which includes a rationalized pricing system, limits on balance billing, a means for addressing overall Medicare expenditures and a program expanding outcomes and effectiveness research. The new law holds the potential for providing greater equity in physician payment, financial protection for beneficiaries, a measure of control in the growth of Medicare expenditures and support for improving the knowledge base on which clinical decisions are made.

Family physicians are encouraged that when fully implemented the new fee schedule should more accurately and appropriately value services, should eliminate troublesome specialty differentials and moderate the significant disparities in payment between urban and rural areas. Furthermore, one of the major benefits of the new fee schedule may be its influence on medical specialty and practice location choice, encouraging more students to choose primary care specialties and practice in rural and other underserved localities. This approach ultimately will benefit patients by providing greater access to many essential primary care services.

However, in order for the benefits of the reform to be realized and the integrity of the package preserved, the transition to and implementation of the four elements must be managed carefully. We encourage this committee to monitor this process to ensure implementation is done in a manner consistent with Congressional intent and within the time frame specified in law.

Therefore, we caution against further changes in Medicare physician payment that could alter the progress made to date. Any modifications in the program should be consistent with and move in the direction of the reform package and assist rather than hinder the transition, as is the case with the proposed increase in the MEI for primary care services. However, many of the Medicare related proposals included in the Administration's budget give rise to significant concern. The Academy's views on selected aspects of the budget proposal are outlined below.

REDUCTION IN PAYMENTS FOR OVERVALUED PROCEDURES

The administration's proposed reductions in payments for procedures that are overvalued in relation to the estimated resource-based fee schedule violate the spirit of physician payment reform by failing to address undervalued services. Previous attempts to constrain Medicare outlays through selective price cuts have only provided an incentive to increase per beneficiary volume of these services. The so-called overpriced procedure cuts have not proven to be a successful method of slowing the growth in Medicare spending and there is little reason to expect that the proposed reductions will be any more likely to achieve their intended effect in FY 1991.

REDUCTION IN PAYMENTS FOR OVERVALUED LOCALITIES

In proposing only reductions in payments for procedures in localities where payments exceed the national average, the administration's proposal has fallen prey to the same flaw in logic evidenced in the overvalued procedure cuts. Reductions alone only provide an incentive to increase volume and have proven remarkably ineffective in constraining the growth in outlays. Reducing payments in some areas while failing to address the perversely low payments in other, mostly rural areas perpetuates the access problems faced by rural beneficiaries while this approach offers little hope of effectively addressing the growth in volume.

Of additional concern regarding reduced payments in overvalued local ties is the use of the existing geographic practice cost index (GPCI) to adjust for alleged geographic differences in practice costs. Our analysis of the GPCI indicates that it is significantly flawed and that it provides an entirely distorted picture of relative practice costs. We are unaware of any data supporting the conclusion that geographic differences in practice costs exist. In fact, if any conclusion is to be drawn from practice cost data, it is that rural practices are slightly more expensive than urban practices, which is opposite to the conclusion reached by the GPCI. I hasten to remind the committee that in OBRA 89 Congress adopted a Finance Committee provision calling upon the Physician Payment Review Commission to study the extent to which practice costs vary geographically and the extent to which the available

GPCI accurately reflects practice costs. At a minimum I urge you to avoid using the GPCI before the studies that you have requested are completed.

PHASE-IN INCREASES FOR NEW PHYSICIANS

Congress previously limited fees for new physicians for two years, at 80 and 85 percent of the prevailing charge levels. Given the historical inequities in calculation of Medicare physician fees, these limits prevented new physicians from entering practice and receiving payment significantly greater than established physicians practicing in the same locality. However, the new proposal would limit payment for new physicians over a five year period, and extend this policy under the new fee schedule. We strongly object to this provision. A principal purpose for developing the new fee schedule is to rationalize payment. Once an appropriate fee for each service is determined, we believe it imperative that Medicare recognize the fee for all physicians providing the given service. We believe it inappropriate to arbitrarily prohibit licensed physicians providing a service from eligibility to receive the payment determined to be rational and appropriate for the particular service, and urge you to reject this proposal as inconsistent with the intent of payment reform.

ASSISTANTS AT SURGERY

The proposed budget calls for paying the same amount for a surgical procedure regardless of whether or not the primary surgeon elects to use an assistant. Only limited exceptions would be allowed. The rationale cited for this proposal is based on the wide geographic variation in the use of physicians as assistants at surgery and in the use of primary care physicians. The proposal would create a disincentive for a physician to provide assistance at surgery and for a surgeon to utilize an assistant. It would encourage surgeons to select assistants who are nurses or hospital staff paid by the hospital because only then could the surgeon keep the entire fee.

Individual situations often require that there be another physician actively participating in the patient's surgical care. Primary care physicians serving as assistants are in a position to recognize that there are unique circumstances surrounding a patient's surgery and the operative complications that may arise. Family physicians are particularly qualified to provide this assistance because of their knowledge of their patients' medical history and the existence of multiple conditions that might complicate a procedure. Family physicians bring to the operating room more than just the technical ability to assist at surgery.

CLINICAL LABORATORY SERVICES

The administration proposes saving $60 million by reducing payment for clinical laboratory services to 90 percent of the median fee schedule amounts for non-profile tests and 80 percent of the median for profile and standardized tests. Fees above the limit would receive no update in 1991. We would urge extreme caution in fee reductions for clinical labs at this time. Clinical laboratories in locations previously unregulated will soon be required to meet stringent regulatory requirements that may threaten the financial viability of a number of laboratories. The regulations are anticipated to create considerable additional costs for physician office laboratories. These costs coupled with the proposed reduction in fees could create significant hardships. We are very concerned that the number of laboratories may be severely diminished, which would threaten patient access to quality laboratory services.

MEDICAID

While this statement has focused primarily on Medicare related issues, I want to take the opportunity to briefly discuss the Medicaid program, specifically as it relates to access to care.

The Academy is increasingly concerned about access to care by the millions of uninsured children and adults and believes that a strategy to provide insurance to this population should include expansion and reform of the Medicaid program. We believe that necessary changes in the Medicaid program must include uniform eligibility levels, a uniform essential benefit package, and payment levels that are consistent with Medicare payment using the resource-based fee schedule. The Academy supports efforts of the Physician Payment Review Commission to examine the Medicaid program and looks forward to working with PPRC and Congress to develop approaches for reforming this program and to develop a plan, utilizing Medicaid as a component for providing access to insurance for all Americans.

REDUCTION IN CAPITAL AND OUTPATIENT PAYMENTS TO RURAL HOSPITALS

Because nearly thirty percent of family physicians practice in rural communities, we share the concern expressed by many of the members of the Finance Committee about the plight of rural hospitals. Rural hospitals do not have a sufficient volume of cases in each DRG to achieve the "averaging" necessary to survive under PPS. As you are well aware, the typical rural hospital is experiencing a negative margin on its Medicare business. The loss of a rural hospital can mean the loss of all community-based health care. The failure of Medicare to pay its full share of capital costs in rural hospitals aggravates an already parlous situation.

We are particularly concerned about the administration's proposal to reduce by 10 percent payment for certain hospital outpatient services and to reduce by 15 percent capital payments for outpatient services in all but sole community hospitals. The administration's proposed outpatient cuts will disproportionately affect rural hospitals, which generate a greater proportion of their Medicare income from outpatient services than do urban hospitals. A primary goal of PPS was to encourage the movement of inpatient care to the outpatient setting whenever that could be accomplished without a decrement in quality. The increase in expenditures for outpatient care should be regarded as an expected result and a sign of the program's success.

In addition, the reductions in payment for outpatient services may also have a negative impact on ambulatory-based graduate medical education programs, as noted below.

CHANGES IN MEDICARE GRADUATE MEDICAL EDUCATION PAYMENTS

The budget proposes changes in two areas relating to Medicare graduate medical education payments. The first relates to the factor used in making indirect medical education payments to teaching hospitals. The proposal would reduce the IME factor from 7.7 percent to 4.05 percent. This proposal would seriously jeopardize many family practice residency programs. With their emphasis on primary care services provided in an ambulatory setting, these teaching programs tend to have costs associated with their training that differ from inpatient based programs. The Institute of Medicine identified some of the factors contributing to the relatively higher costs of ambulatory training compared to inpatient training such as the need for additional space. As reductions in the Medicare indirect GME payment cause hospitals to evaluate their commitment to medical education programs, we are concerned that ambulatory-based primary care residency programs such as family practice will become less attractive to hospitals.

Similarly, we are concerned about the impact of the proposed "reform" of direct GME payments. The proposal would establish a per resident payment derived from the national average of FY 1987 resident salaries updated by the CPI, with primary care residents weighted at 180 percent of the per resident amount. The proposal would, by basing the payment on salaries alone, disregard the other important elements of direct costs of graduate education presently recognized by the Medicare program, such as faculty, classroom and other costs. While the suggestion of a higher weighting factor for primary care programs is attractive, the recalculation of direct costs would result in a significant payment reduction to teaching hospitals. The anticipated effect, given the financial fragility of primary care teaching programs, would be a threat to their viability as the Medicare revenues to teaching hospitals are further diminished.

SUMMARY

The American Academy of Family Physicians strongly supports reform of Medicare physician payment recently enacted by Congress. We believe that implementation of this plan will result in a greatly improved Medicare payment system—improved from the perspective of Congress, beneficiaries and physicians. However, we must ensure that the transition to and implementation of the plan is consistent with the comprehensive reform enacted by Congress. Further modifications to Medicare payment and policy must be consistent with the reform in order to preserve its integrity. We urge this committee to reject Medicare budget proposals that would disrupt the positive action taken by Congress. We further caution against additional changes in Medicare payment to hospitals that would jeopardize primary care education and impede access to care.

Thank you again for the opportunity to share the views of the American Academy of Family Physicians. We look forward to working with you as we move toward an improved Medicare program.

Responses to Questions From Senator Bentsen

Question. Dr. Czarsty, in your statement you suggest that past reductions in payments for physician services have created an incentive for affected physicians to increase the volume of their services—and that such behavior has frustrated efforts to restrain the growth in expenditures. This viewpoint is considerably different from what the Committee heard from physician organizations during our deliberations on physician payment reform, and it has disturbing implications. Are you saying that there is no effective way of restraining the growth in expenditures for physicians' services? How would you advise the Committee to address the problem?

Answer. The overpriced procedure cuts have not proven to be a successful method of slowing the growth in Medicare spending due to per beneficiary volume increases. What must be accomplished to reduce volume is to remove the distortions in the incentives to physicians concerning what services to provide. We believe payment reform creates incentives to provide less costly substitute services by increasing reimbursement for those services. Payment cuts in the absence of payment reform, will not reduce volume or overall Medicare spending.

When Congress enacted physician payment reform, it adopted a package, which includes a means far addressing overall Medicare expenditures through Medicare Volume Performance Standards and a program expanding outcomes and effectiveness research. By basing fee updates on how expenditure growth compares with a performance standard, the medical profession is given an incentive to slow expenditures growth. We support establishing separate targets based on category of physician services and believe this will enable identification, monitoring and control of services with increased volume. In addition, practice guidelines will increase appropriate use of medical resources by providing physicians and payers with the information they need to make better choices about appropriate medical care.

Should you have any additional questions, we would be pleased to respond to them.

Prepared Statement of Paul A. Ebert

Mr. Chairman and members of the Subcommittee, I am Paul A. Ebert, MD, FACS, Director of the American College of Surgeons (ACS). The College appreciates this opportunity to present its views on the President's proposed fiscal year 1991 Medicare budget.

As you know, Mr. Chairman, the American College of Surgeons was an active participant in and supporter of this committee's work last year as it developed the physician payment reform legislation that was approved by Congress last fall. We were particularly pleased to work with you and your staff to develop the Medicare Volume Performance Standard (MVPS) rate of increase concept, and the establishment of a separate standard for surgical services. The College was, and still is, very much committed to working with you and other policymakers to develop reasonable approaches to public policy problems relating to Federal programs like Medicare. We are also committed to working with the Secretary of Health and Human Services and his staff to implement the new MS program and other elements of the payment plan.

However, Mr. Chairman, when we looked at the Administration's budget a few weeks ago, we began to wonder how interested the President's advisers really are in working with physician organizations to implement the new Medicare program changes in an orderly and reasonable manner. It appears to us that no one in the Administration seems to be aware of the fact that less than two months before this budget was submitted, Congress approved, and the Administration supported, major revisions in Medicare's approach to physician payment.

We believe that changes in the design of a program as complex and as important as Medicare should proceed in the most orderly manner possible. Disruptions should be kept to a minimum, and changes in Medicare policy should be judged on their long-term implications for patient access to high-quality surgical and medical services. In our judgment, the Administration's 1991 budget proposal meets none of these criteria and should be rejected. We recommend that Federal policymakers give the new Medicare payment reform plan a chance to take effect before adopting additional policy changes that could interfere with its implementation.

MEDICARE ECONOMIC INDEX (MEI) UPDATE FOR PHYSICIANS' SERVICES

Consider, for example, the recommendation in the President's budget that an MEI update should be provided only for primary care services. According to the Adminis-

tration, this recommendation would improve equity in relative payment levels for physicians' services. But in his October 1989 report to Congress entitled Implementation of a National Fee Schedule, Secretary Sullivan observed that "significant lead time is needed before implementation of a new payment system based fully on RBRVS. This is needed to assure reasonable accuracy in payment determinations."

A few months ago, Congress approved the adoption of a new Medicare fee schedule plan that will make adjustments in the relative value of various physicians' services on a phased-in basis. Congress also agreed that the RBRVS would be implemented only after further research has been completed to determine exactly what the relative values among such services are. We think that was a prudent decision. In addition, preliminary estimates using the RBRVS suggest that some non-primary care services are undervalued. Thus, until the new plan goes into effect, we believe it is appropriate for all physicians' services to be subjected to the same update rules.

"OVERVALUED" SERVICES

We are especially disappointed with, and strongly object to, the Administration's plan to again single out certain procedures, including many important surgical procedures, for payment reductions on the grounds that those services are "overvalued" when compared with a resource-based Medicare fee schedule—a schedule that hasn't even been established yet.

The information and data upon which the "overvalued" proposal is based are, in our judgment, flawed, inaccurate, and certainly incomplete. Our observations are borne out by the fact that currently there are major studies under way to re-examine certain services. These studies have been undertaken because of legitimate doubts that have been raised about the methodology and the quality of the original research effort that was used to justify payment reductions for those services. Moreover, there are many other physician specialties that are being studied for the first time, and the results of these studies will affect the final values assigned to all Medicare services. We think that this work should be completed and thoroughly evaluated before further arbitrary and selective payment adjustments are made solely for short-term budgetary goals.

The College believes that Congress was correct last fall when it included in the statute a specific time frame and instructions to be followed by the Secretary and the Physician Payment Review Commission before other payment modifications are made on the basis of limited information.

ASSISTANCE-AT-SURGERY

Mr. Chairman, the College believes that the Committee should firmly reject the Administration's proposal related to the use of and payment for assistance-at-surgery. This proposal reflects a lack of understanding of why an assistant-at-surgery may be needed during an operation. In addition, it proposes to simply ignore the fact that the use of an assistant-at-surgery involves the application of skills and knowledge that must be fairly valued and reimbursed by the Medicare program. I'd like to spend a few moments to expand upon our concerns in this area.

The College has developed guidelines for determining when an assistant-at-surgery is required for a procedure. We believe the application of the guidelines has a direct bearing on both the quality and safety of the surgical services that are provided to a patient. The factors that a principal surgeon should consider in deciding when an assistant is needed include:

- The degree to which the operation is complex and technically demanding, so that joint efforts of the principal surgeon and one or more assisting physicians contribute meaningfully to the successful treatment of the patient.
- The expected effect of the use of an assistant on the patient's mortality and morbidity, including that related to blood loss and duration of the operation.
- The degree to which the patient's history indicates that there is a substantial risk of complications arising in the course of the operation that would require the services of an assistant-at-surgery to avoid the increased risk of mortality or morbidity.

On the basis of these criteria, it may be possible to identify those procedures that almost always require the use of an assistant-at-surgery, and those for which an assistant is almost never required. However, it should be emphasized that for other procedures, professional judgments are necessary to determine whether an assistant should be used in a specific case. The College believes that the responsibility for determining the need for an assistant-at-surgery rests squarely with the principal sur-

geon. Thus, it is our view that payment for assistance-at-surgery should be made only when the services of an assistant have been ordered by the operating surgeon.

Ideally, an assistant-at-surgery should be a surgeon or an individual who has the necessary qualifications to participate in a particular operation and who actively assists the surgeon in performing the surgical procedure. In many teaching hospitals, for example, surgical residents are frequently available to provide such assistance. However, an extra pair of surgically trained hands is not always available when needed, so the individual circumstances of each particular case must dictate whether assistance from a non-surgeon is appropriate.

The committee should also know, Mr. Chairman, that at least one state, New Jersey, actually requires the presence of a physician as an assistant during major surgery, so that the surgeon is allowed no discretion with regard to this matter. In other areas of the country, the use of a physician as an assistant-at-surgery may be required for certain major operations by the quality assurance program of the hospital.

As you know, the costs of the services of non-physician assistance-at-surgery are covered in various ways under the Part A portion of the Medicare program, while payments for the services of a physician who performs as an assistant are reimbursed under Part B. We believe that physicians who serve as assistants-at-surgery should be reasonably compensated for their services, as should any physician who provides a professional service. It is also our view that a physician whose presence is required during an operation should be paid on the basis of the services he or she actually provides. For example, a physician who serves as a consultant should be paid a consultation fee, and should not be paid as an assistant-at-surgery.

Finally, Mr. Chairman, in the legislation passed by Congress last year, you directed the Physician Payment Review Commission to conduct a study of Medicare policies that are related to the appropriate use of assistance-at-surgery and the payment rules that should be applied under the new payment system. We hope that you will wait for the results of this additional study and will reject the Administration's ill-conceived proposal in this area.

SURGICAL GLOBAL FEES

The budget proposal would reduce global surgical fees to reflect recent decreases in the average inpatient length of stay among Medicare patients. In our opinion, this recommendation makes no sense whatsoever. In the first place, we see no evidence at all that physician time and effort related to surgical patients are linked to the length of stay. These patients must be followed after the operation, and postoperative visits are provided on an outpatient rather than an inpatient basis. In fact, earlier hospital discharges may actually increase the amount of physician effort that is needed to monitor and/or treat the patient during the recovery period. Secondly, the Administration seems to have overlooked the fact that increasing numbers of surgical procedures are performed on an outpatient basis. It certainly makes no sense to use data on inpatient length of stay to make payment reductions for surgical services that are typically provided on an outpatient basis.

Once again, Mr. Chairman, the Administration seems to be ignoring the payment legislation that was passed just a few months ago, in which you directed the establishment of standard definitions and procedure codes for all physician services, including global surgical services. The values assigned to packages of services are to be based upon yet-to-be-completed estimates of the resource inputs needed to provide those services, including those related to postoperative care. The Administration plan calls for making reductions in payments without taking any of these factors into consideration.

BUDGETARY OPTIONS

In summary, Mr. Chairman, we are very disturbed by the Administration's 1991 budget package, because it totally disregards the steps that have been taken to bring about an orderly revision in physician payment policies. We recommend that virtually all of these proposals be rejected.

Nevertheless, we also recognize that budget realities may compel the committee to achieve budgetary savings in some form. Thus, the American College of Surgeons urges that if such actions must be made, they take the form of across-the-board fee reductions that will be applicable to all physicians' services for the upcoming period prior to implementation of the new payment plan. Even the across-the-board reductions that would apply to the Medicare program under a budget sequestration order would make more sense to us than actions that would disrupt the phased-in changes scheduled to begin in 1992.

Again, Mr. Chairman, the American College of Surgeons appreciates this opportunity to express its views, and I would be pleased to answer any questions you may have.

Responses to a Question Submitted by Senator Bentsen

Question: In his testimony, Dr. Lee has indicated that it may be possible to refine the Administration's proposal to reduce payments to surgeons who use an assistant-at-surgery by limiting payment reductions to those procedures for which an assistant is clearly unnecessary. Would you care to comment on this approach?

Response: The College certainly agrees, Mr. Chairman, that use of an assistant-at-surgery should be medically necessary. The use of the assistant is explicitly intended to enhance the quality and the safety of the surgical services that are provided to the patient. As we indicated in our testimony, the College believes it is possible to identify those procedures, based on sound clinical judgment and experience, that almost always require the use of an assistant-at-surgery, and those for which an assistant is almost never required. We certainly think that this is a much more reasonable approach than the Administration's proposal, and we plan to share our recommendations in this area with Dr. Lee and the Physician Payment Review Commission.

Prepared Statement of Kenneth W. Gideon

Mr. Chairman and Members of the Committee: I appreciate this opportunity to discuss with you today the revenue proposals contained in the Bush Administration's budget for fiscal year 1991. These proposals are designed to advance the Administration's goals of enhancing economic growth and improving our nation's ability to compete in an integrated world economy.

My oral remarks today will focus on Part I of my written testimony which sets forth the procedures followed by Treasury's Office of Tax Analysis (OTA) in estimating the budget impact of the Administration's capital gains proposal. Part II of my written testimony contains a more detailed explanation of the capital gains proposal, the Family Savings Account, and first-time homebuyer proposals proposed by the President and introduced in the Senate as S. 2071 by Senators Packwood, Dole and Roth, as well as other significant revenue proposals in the budget.

PART I.—OFFICE OF TAX ANALYSIS ESTIMATES OF THE REVENUE EFFECTS OF THE PROPOSED REDUCTION IN CAPITAL GAINS TAX RATES FOR INDIVIDUALS

As is now well known, OTA estimates that the President's capital gains proposal, if enacted, would raise revenues $12.5 billion over the budget period and provide modest increases in revenue thereafter. The staff of the Joint Committee on Taxation (ACT) estimates that the proposal will lose $11.4 billion over the same period and continue to lose money thereafter. Like others, I am both concerned and surprised by the $23.9 billion gap between the OTA and JCT estimates. Indeed, the disparity in these estimates contrasts sharply with the closeness of the estimates made by both staffs with respect to most of the Administration's other revenue proposals.

Under the circumstances, I believe it is essential for this Committee to understand the procedures used by the Office of Tax Analysis to produce its estimates of the proposal. Accordingly, I am providing in my testimony today a detailed presentation of the assumptions, data, and methodology used to produce the OTA estimates. I am sure that the JCT will wish to provide similar detail with respect to its estimates (including the CBO data on which its estimates are based). I call on the JCT and CBO to do so as promptly as possible. This Committee, indeed, the Congress and the American people are entitled to detailed disclosure of the assumptions and methodology of the estimators when the estimates vary so significantly on an issue of major importance. Because we do not now have the level of detail with respect to the JCT estimates which we have disclosed today with respect to the OTA estimates, our analysis of the factors giving rise to the difference is not complete.

Summary of Critical Differences in OTA and JCT Revenue Estimates

Based on our current information, we have identified two major differences.

• OTA's estimates imply that tax revenues from sales of capital assets would be maximized if taxed at a 23 percent rate (*i.e.*, the "revenue maximizing rate"). It appears to OTA that JCT's analysis implies that such revenues would be maximized at a rate around 35 percent—significantly above the current maximum average rate of 28 percent on *ordinary* income. OTA analysts find it implausible that tax revenues

from sales of capital assets would increase if taxed at rates *higher* than rates applicable to ordinary income. Stated more technically, the JCT's elasticity is lower than that used by OTA and appears to be lower than the elasticity JCT used last year, which is at a very low end of the range of existing estimates. We think it is simply too low.

• The JCT estimate apparently assumes a very large increase (perhaps more than 50 percent from 1988—the last year for which we have data—to 1990) in the level of capital gains that would be recognized if there were no change in law. An increase of this magnitude does not accord with historical experience and is, in our judgment, highly improbable.

These differences take on significance because we should remember that the estimators—both OTA and JCT—have been wrong on this issue before. Both substantially *underestimated* the capital gains revenues which accrued after the 1978 rate cut.

Absence of Macroeconomic Effects from Both Estimates

Neither the OTA nor JCT have included macroeconomic or "feedback" effects. While this accords with the standard practice of both staffs, it does not mean that such positive effects will not occur, merely that they are not estimated.

Secretary Brady, CEA Chairman Boskin, and probably many members of this Committee share the realistic expectation that positive economic effects will occur if the cost of capital is reduced through a capital gains rate cut. As Professor Martin Feldstein recently noted in testimony before the House Budget Committee even a "microscopically small 4 one-hundredths of one percent" increase in the annual growth rate of GNP would produce additional tax revenues of approximately $5 billion per year.[1] Expressed as a decimal, that's only 0.0004.

Such growth would benefit all Americans—not just sellers of capital assets. Indeed, the need to provide a fiscal climate conducive to creating new jobs is what this debate ought to be about rather than an arcane dispute over revenue estimates.

In addition to the macroeconomic effect of having a lower cost of capital, a lower capital gains tax would also permit the existing stock of capital to move to more efficient uses. Neither OTA nor JCT took these potential efficiency gains into account in making the estimates.

Effects of the Proposal on Revenues

The academic studies on the effect on Federal tax revenues of changes in capital gains tax rates agree that capital gains tax rates do have substantial effects on capital gains realizations, although there is wide variation in conclusions about the magnitude of the effect. Indeed, there is no disagreement between OTA and JCT that this effect exists. It is reflected on line II of both estimates. (Tables 2 and 3.) There is disagreement on its magnitude.

OTA's revenue estimate was made after a careful review of the major empirical studies by experts in government and the academic community. Compared to the results in most of the studies, OTA's estimate of induced realizations is conservative. Table 1 provides detail on these studies. I would point out that the long-run elasticity used by OTA in its present estimates is at least as conservative as every study conducted by the U.S. Department of Treasury. Treasury economists including Gerald Auten, Robert Gillingham, John Greenlees, and William Randolph have all found much higher elasticities. By any reasonable standard, OTA has endeavored to err on the side of caution when estimating these behavioral effects.

Before analyzing the OTA estimate in detail, let me make one point about its source. The revenue estimates reported in the budget were produced by the nonpolitical, professional, career, civil-service staff of Treasury's Office of Tax Analysis, which provides all Treasury revenue estimates for other legislative and budget proposals. The OTA staff makes use of the best data and analysis available within the

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[1] Speaking of the JCT estimate, Professor Feldstein stated that: "If . . . the improved incentives for saving, investment and entrepreneurship were to increase the annual growth rate of GNP between now and 1995 by even a microscopically small 4 one-hundredths of one percent—for example, from the CBO's estimate of an average 2.44 percent real GNP growth per year to 2.48 percent—the additional tax revenue would be about $5 billion a year and would turn their estimated revenue loss into a revenue gain. In short, the potential economic advantages of the capital gains reduction are substantial and the potential revenue loss is doubtful at best. The difficulty of estimating the effects of the capital gains exclusion is far too great to put any confidence in the $3 billion staff estimate. But even if that is accepted at face value, the slightest improvement in real economic performance would be more than enough to turn that revenue loss into a revenue gain."

time frame allowed for revenue estimates and updates its data and methods as new information becomes available.

Both the OTA and JCT estimating staffs vigorously defend their independence and professionalism. It is worth stressing, therefore, that the difference in revenue estimates is a professional difference of opinion. Accordingly, the estimates should be evaluated on their merits—not their political appeal.

Explanation of Table 2: Revenue Effects of the President's Capital Gains Proposal

Table 2 shows the revenue effect of significant elements of the President's capital gains proposal as estimated by OTA. In addition, it shows the effect of taxpayers' behavioral responses incorporated in the estimate. The comparable table published by the JCT is attached as Table 3.

1. *Effect of Tax Rate Reduction on the Level of Current Law Realizations.* The first row of Table 2 shows the revenue loss that OTA estimates would result from reducing tax rates as provided in the President's proposal based on the level of capital gains that would have been realized at current law rates, that is, without any behavioral response to the new law. This "static" revenue loss results from applying the proposal to all individually held assets. It is estimated to reduce revenues by $14.1 billion in 1991. The static loss generally grows gradually thereafter with growth in the overall economy.

The basis for these calculations is shown in Table 4. OTA estimates that $214 billion of net capital gains would be realized in 1990 and that this amount would grow to $300 billion by 1995 with no change in the law.

2. *Effect of Taxpayer Behavior.* The second row of Table 2 shows the net additional revenue collected as a result of changes in taxpayer behavior. Lower tax rates on capital gains will induce taxpayer's to realize more capital gains than they otherwise would have. These induced gains are composed of taxable realizations that would otherwise have been tax-exempt because they would have been traded in a like-kind exchange, held until death, or donated to charities, as well as capital gains realizations accelerated from future years and gains arising from portfolio shifting to capital gains assets from consumer durables or other investments.

The additional revenue from increased realizations of capital gains is partially offset by the estimated effects of conversion of ordinary income into capital gains. Taxpayers have found various ways to convert ordinary taxable income into capital gains. Many conversion techniques utilized before 1986 have been eliminated or sharply restricted by the provisions of the 1986 Act, but a capital gains tax rate differential is likely to encourage taxpayers to shift to sources of income which qualify for lower tax rates. In order to make the estimate as accurate as possible, OTA estimated this effect as well.

As indicated by a comparison of rows I and IIa in Table 2, OTA estimates that revenues from induced realizations more than offset the static revenue loss on baseline gains. This conclusion is based on the responsiveness of taxpayers to changes in the capital gains tax rate, which has heretofore been the central aspect of the debate over capital gains and revenue.

The measure of taxpayer responsiveness is generally characterized as the "elasticity" of realizations with respect to the capital gains tax rate, defined as the percentage increase in capital gains realizations divided by the percentage decrease in the overall capital gains tax rate. (Henceforth, for brevity I will refer to this measure simply as the "elasticity.")

OTA's assumption about capital gains elasticities is based on a review of government and academic studies examining the question, all of which are publicly available. Even a cursory review of these studies, listed in Table 1 to this testimony, reveals that while there is a great deal of variation in estimated elasticities, there is a strong consensus that tax rates have significant effects on capital gains realizations. This result accords with intuition and simple common sense. Stated more plainly, lower rates induce more realizations and higher rates cause taxpayers to defer capital asset sales. The decision to realize a capital gain is generally highly discretionary. Hence, the decision is quite sensitive to the individual's tax environment. It is important to note that even small differences in elasticities can have large consequences for revenue estimates.

I would point out in this connection, that we have far better information with which to predict the effects of changes in capital gains rates than we did in 1978, when Congress last legislated a cut in the capital gains rate. We have considerable data from the 1978 tax cut, as well as data from the further reduction in capital gains rates resulting from the reduction in the top marginal income tax rate from 70 percent to 50 percent in 1981, which had the effect of lowering the top rate on long-term capital gains from 28 percent to 20 percent. The data resulting from the

behavioral response to these tax changes provide a rich base from which to estimate the effects of further capital gains rate changes.

As Table 1 indicates, the elasticity estimates used by Treasury are smaller than the elasticities found in nearly all of the studies. OTA assumes an elasticity of 1.2 in the short-run, declining to about 0.8 in the long-run. An implication of this elasticity is that the average marginal tax rate that would maximize revenues from the capital gains tax is about 23 percent. In other words, a rate either higher or lower than 23 percent would produce less revenue than a 23 percent rate.

While the implied revenue maximizing rate is a useful way to convey the concept of elasticity in a form which is more comprehensible to noneconomists, the revenue maximizing rate is not ideal from the standpoint of economic efficiency and growth. It is instead the upper limit at which tax should be imposed. While a higher tax rate always imposes efficiency losses on the economy by comparison to a lower rate, imposing tax at a rate above the revenue-maximizing rate would cause revenue loss as well.

OTA's estimates for this year do reflect a change in elasticity from the elasticity which we used last year. Last year OTA utilized a long-run elasticity of 0.9 rather than the 0.8 used this year. OTA changed its elasticity in its normal process of updating its model and in an effort to be cautious. The direction of the change would, absent changes in the JCT's elasticities, have narrowed the gap between the estimates considerably.

For purposes of easy reference, Table 5 sets forth OTA's elasticity assumptions for this year and last year. In the OTA model, the value of the elasticity depends on the value of the marginal tax rate—the higher the marginal tax rate, the higher the elasticity. Hence, to allow comparability across years, all elasticities are evaluated at a 20 percent marginal tax rate. That is, each elasticity is calculated as if the marginal tax rate were 20 percent. Table 5 also shows the marginal and average tax rates assumed each year.

3. *Depreciation Recapture as Ordinary Income.* The effect of the recapture is to limit the exclusion for depreciable assets to the increase in value over the original cost basis of the depreciable asset. OTA estimates that depreciation recapture would generate $4.6 billion over the 5 year budget period.

4. *Effect of the Alternative Minimum Tax.* Under our proposal, the excluded portion of long-term capital gains will be subject to the alternative minimum tax. This provision has a significant revenue effect. OTA estimates that it adds $2.5 billion to revenues over the 5 year period.

The revenue estimate of the proposal is significantly affected by the recapture and alternative minimum tax provisions. Indeed, these provisions account for the fact that the proposal generates a net revenue gain in 1993 and later years. The importance of depreciation recapture is due to the fact that depreciable assets account for approximately 40 percent of all net capital gains.

Revenue Effects After the Budget Window

I also wish to point out that OTA has provided revenue estimates only through FY 1995. This is because the estimate is based on the baseline macroeconomic forecast for the United States economy provided by the "Troika," a committee whose members represent the Office of Management and Budget, the Council of Economic Advisers and Treasury. The Troika baseline forecast extends only through 1995. Any extrapolation of the baseline beyond 1995 either would require a purely mechanical approach (*e.g.*, an assumption that economic trends would continue unchanged in the future) or would involve an independent forecast of such trends. Either approach would be arbitrary and could well result in the use of economic assumptions inconsistent with those underlying the Troika 5 year forecast. In addition, any baseline assumptions made by the OTA staff would likely create a debate about out-year macroeconomic growth which OTA has traditionally avoided. Because of these concerns, we and the JCT, have concluded that point estimates for periods beyond the budget window generally will not be provided.

We believe it is appropriate, however, to state OTA's views as to the revenue trend expected in periods after the budget period. OTA projects that, if enacted, the President's proposal would raise revenue modestly in all years following the 1991–1995 budget period.

Distributional Effects of the Capital Gains Proposal

The purpose of the Administration proposal is to increase the incentives for saving and investment and increase the efficiency of capital transactions. Fulfillment of these goals will benefit all Americans. A review of Table 6 also shows that enactment of the proposal would not reduce the tax burden of the wealthy. Indeed, they would pay more.

The conventional approach to measuring tax burdens is based on the amounts of taxes paid by income class. The distributional effect of a tax change is determined from the distribution of taxes paid before and after the enactment of the proposal. The change in taxes paid is an indicator of the change in tax burden.

For some types of tax proposals that cause only small behavioral responses, it is sufficient to show the amount of tax change on the original amount of income reported before the tax change. However, as discussed above, all analysts agree that capital gains realizations are very responsive to changes in tax rates. Therefore, in analyzing the distributional effects of capital gains tax changes, the behavioral responses of taxpayers should be taken into account to obtain a reasonable estimate of changes in tax payments.

OTA's analysis of the distributional effects of the fully phased-in Administration proposal on capital gains taking into account the behavioral responses of taxpayers is shown in Table 6. (The calculations are done assuming the proposal is fully phased in at 1990 levels.) The table demonstrates that once the dynamic responses of taxpayers are taken into account, the amount of taxes paid by high-income taxpayers will increase. Taxpayers with incomes of $200,000 or more will pay almost a billion dollars in additional capital gains taxes. The share of taxes paid by lower and middle-income taxpayers will decline since their taxes do not increase so significantly.

For purposes of comparison, Table 6 also shows how taxes paid would change without taking behavioral changes into account. The distribution of changes in capital gains taxes under the "no behavioral change" assumption appears to show that high-income taxpayers would receive large tax reductions. Dynamic distribution analysis, however, clearly indicates that these high-income taxpayers would pay more in taxes.

Thus, dynamic analysis shows that a capital gains tax cut provides a "win-win" situation: while high-income taxpayers would pay more in taxes, they would be better off because the lower capital gains tax rates will allow them to make investment decisions with less concern about the tax impact. They will have chosen to pay the additional taxes voluntarily. Taxpayers with lower incomes will not pay more unless they also benefit from the rate cut. Overall, the result is to collect relatively more taxes from those with higher incomes.

It should also be pointed out that in Table 6, taxpayers are classified according to their average income over a period of years, which is referred to as "permanent income." A single year measure of income that includes capital gains fails to classify many taxpayers in the correct income class. In particular, the use of single year income including gains classifies many middle-income taxpayers with large one-time gains from the sale of a small business, a farm or a personal residence as "high-income." As a result, the share of capital gains attributed to high-income taxpayers is overstated. This approach counts the gains of one-time realizers and others whose income is temporarily high as being high-income taxpayers. An alternative approach is to classify taxpayers by income other than capital gains. A preferred approach is to classify taxpayers by their permanent income. While ideally one would want to compute the average income over the taxpayers' lifetimes, available data allow us to do so only over 5 years. By averaging a taxpayer's income over 5 years, the effects of temporary income spikes are substantially reduced and overcorrection is also avoided. This is the methodology used in Table 6.

JCT's distributional table is based solely on the static portion of its estimate. In other words, in presenting its distribution tables, JCT ignores the dynamic part of its own estimate. The JCT table is therefore a distribution of the benefits of a rate cut to those who would have sold capital assets in any event, but ignores distribution of the additional tax paid by those who will be induced to sell at lower rates. Table 6 provides a more complete and accurate picture than the JCT table.

Comparison of OTA and JCT Estimates

Table 7 summarizes the principal differences between the Treasury estimate of the revenue impact and the Joint Committee on Taxation (JCT) staff estimate. Table 7 demonstrates that the total difference over the 5 year budget period is $23.9 billion. The two main sources of differences are in the estimates of the static revenue loss (Line I) and the assumed responsiveness of taxpayers (Line II).

The static revenue loss is obtained by multiplying the change in the average tax rate on capital gains times the volume of realizations that would have occurred with no change in the law. The level of realizations that would have occurred with no change in the law is referred to as the "baseline" level of realizations. Differences in static revenue loss estimates can result from differences in baseline capital gains and/or differences in the tax rates used. The table shows that over the 5 year

period, the discrepancy in the static revenue loss estimates is $15.7 billion. We are not able to separate the part of the JCT estimate due to the average tax rate and the portion due to CBO's estimates of capital gains realizations.

As mentioned earlier and documented in Table 4, OTA estimates that baseline capital gains would increase gradually along with growth in the economy. We understand that the JCT's baseline, which is provided to it by the CBO, is assumed to jump by over 50 percent from 1988 (the last year for which data are available) to 1990. OTA believes that the extraordinary increase in capital gains realizations projected by CBO for this 2 year period is highly improbable. Its effect is to raise the baseline level of realizations quite significantly throughout the budget window, thereby significantly enlarging JCT's estimates of the static revenue losses.

Another major difference between the OTA and JCT estimates is that the JCT estimate appears to assume a lower level of responsiveness (elasticity) by taxpayers. OTA revenue estimators tell me that the only way they could replicate their long-term results in their model would be to assume that the revenue maximizing rate is around 35 percent. Recall that the comparable rate for OTA is approximately 23 percent. The implication of the JCT revenue maximizing tax rate is that the capital gains tax rate could be raised to a level significantly higher than the current tax rates on ordinary income such as dividends and interest, and total capital gains revenue would continue to increase. As noted above, OTA is aware of no study which suggests that revenues would increase if the capital gains tax rate were significantly higher than the rate of tax on ordinary income, yet that is the apparent implication of the long-run elasticities utilized by the JCT in making its estimates. Indeed, virtually every study in Table 1 that allows computation of a revenue maximizing rate implies that the maximizing rate is below the rate imposed on ordinary income. This is hardly surprising since, just as we anticipate a portfolio effect for a rate differential in favor of capital assets, one would also expect taxpayers to attempt to shift out of capital assets if the rates imposed on them were higher than ordinary rates. The considered professional judgment of Treasury analysts is that the JCT elasticity is simply too low.

Although OTA anticipated that the JCT staff would find that the proposal will lose revenue over the budget period, OTA and I were frankly, surprised at how large their predicted loss was. Based on JCT's analysis of last year's proposal, we had supposed that the JCT would show a significantly lower loss over the budget period 1990–1995, rather than the $11.4 billion loss recently reported. In part, this is no doubt due to CBO's revision of baseline capital gains realizations. However, it also seems clear that the JCT also reduced its elasticity assumption as well. While both Treasury and JCT analysts regularly update and improve their models as new information becomes available, this particular revision apparently caused the JCT to increase the loss it estimated for the President's proposal, and increased rather than narrowed the gap between the two estimates.

The revenue estimators of OTA are professionals who have labored to produce their best judgment of the revenue effects of the President's proposal. I am not an economist—and I share much of the perplexity of members of this Committee with respect to how to evaluate this important disparity. A few of my personal thoughts may be of some utility to the Committee.

First, "elasticity" is a term that speaks mainly to economists. OTA estimators tell me that we can infer a revenue maximizing tax rate from these elasticities. Specifically, OTA's estimate implies that revenue would be maximized if the rate were set at 23 percent, and the JCT's estimate appears to imply that we would maximize revenue if the rate were around 35 percent. Based on our historical experience with capital gains since 1978 I find it more likely that we will raise revenue through a rate cut than through a rate increase above ordinary rates.

Second, I do not find it plausible that a 50 percent jump in capital gains realizations will occur in a 2 year period without a change in tax law. Yet that is apparently what CBO has projected and hence what the JCT is required to include in its base line estimates.

Finally, lowering the capital gains rate will lower the cost of capital and should promote economic growth. Even trivial increases in GNP, as noted above, will generate revenues more than sufficient to offset even the JCT estimates. The prospect of increased economic growth emphasizes the fact that this debate should not be about technical estimating problems. It is about making this country more competitive.

Since the estimators have been unable to resolve their differences, however, Congress and the American people clearly should have all the data, assumptions, and methodology underlying the estimates placed on the record for full public scrutiny. We have done that today and we look forward to disclosure of the same material

with respect to the JCT estimates and CBO projections on which it is based at the earliest possible time.

Thank you, Mr. Chairman. I will be pleased to answer questions at this time.

PART II.—DETAILED DISCUSSION OF THE ADMINISTRATION'S REVENUE PROPOSALS CAPITAL GAINS TAX RATE REDUCTION FOR INDIVIDUALS

Description of the Proposal

In general, the Administration proposes that the capital gains tax rate for individuals be reduced on long-term investments by enacting a sliding scale exclusion for long-term capital gains. The proposal provides for a 10, 20, or 30 percent exclusion for long-term capital gains on assets held by individual taxpayers for 1, 2 or 3 years, respectively. The three year holding period requirement will be phased in over three years.

Holding Periods. Individuals will be allowed to exclude a percentage of the capital gain realized upon the disposition of qualified capital assets. The amount of the exclusion will depend on the holding period of the assets. Assets held 3 years or more will qualify for an exclusion of 30 percent. Assets held at least 2 years but less than 3 years will qualify for a 20 percent exclusion. Assets held at least 1 year but less than 2 years will qualify for a 10 percent exclusion.

As a result of the exclusion, the tax rate applicable to capital gains on qualified assets held for at least 3 years will be 19.6 percent for a taxpayer in the 28 percent tax bracket. Similarly, investments held by such a taxpayer between 2 and 3 years will be taxed at a 22.4 percent rate, and assets held between 1 and 2 years will be taxed at a 25.2 percent rate. Individuals in the 15 percent tax bracket will pay proportionally lower rates of tax (13.5 percent, 12.5 percent, and 10.5 percent, respectively).

Qualified Assets. Qualified assets will generally be defined as any assets qualifying as capital assets under current law and satisfying the holding period requirements, except for collectibles. Collectibles are assets such as works of art, antiques, precious metals, gems, vintage alcoholic beverages, and stamps and coins. Assets eligible for the exclusion will include, for example, corporate stock, manufacturing and farm equipment, a home, an apartment building, a stand of timber, or a family farm.

Phase-in Rules and Effective Dates. The proposal will be effective generally for dispositions of qualified assets after the date of enactment. For the balance of 1990, the full 30 percent exclusion will apply to assets held at least 1 year. For dispositions of assets in 1991, assets will be required to have been held for 2 years or more to be eligible for the 30 percent exclusion, and at least 1 year but less than 2 years to be eligible for the 20 percent exclusion. For dispositions of assets in 1992 and thereafter, assets will be required to have been held at least 3 years to be eligible for the 30 percent exclusion, at least 2 years but less than 3 years for the 20 percent exclusion and at least 1 year but less than 2 years for the 10 percent exclusion.

Additional Provisions. The excluded portion of capital gains will be added back in when calculating income under the alternative minimum tax. Installment sale payments received after the effective date will be eligible for the exclusion without regard to the date the sale actually took place. For purposes of the investment interest limitation, only the net capital gain after subtracting the excluded amount will be included in investment income.

Depreciation deductions taken with respect to all depreciable property will be recaptured in full as ordinary income. This provision prevents taxpayers from benefiting from the exclusion provision for depreciation deductions that have already been claimed in prior years. To the extent that depreciable assets have increased in value above their unadjusted basis, taxpayers will be able to benefit from the exclusion.

Reasons for the Proposal

Restoring a capital gains tax rate differential is essential to promote savings, entrepreneurial activity, and risky investment in new products, processes, and industries that will help keep America competitive and economically strong. At the same time, investors should be encouraged to extend their horizons and search for investments with longer term growth potential. The future competitiveness of this country requires a sustained flow of capital to innovative, technologically advanced activities that may generate minimal short-term earnings but promise strong future profitability. A preferential tax rate limited to longer term commitments of capital will encourage business investment patterns that favor innovations and long-term growth over short-term profitability. The resulting increase in national output will benefit all Americans by providing jobs and raising living standards.

In addition to the improvements in productivity and economic growth, a lower rate on long-term capital gains will also improve the fairness of the individual income tax by providing a rough adjustment for the taxation of inflationary gains that do not represent any increase in real income. In addition, it provides relief from the double taxation of investments in corporate stock.

Incentives for Longer Range Investment. A capital gains preference has long been recognized as an important incentive for capital investment. The first tax rate differential for capital gains in this country was introduced by the Revenue Act of 1921. For the next 65 years there was always some tax rate differential for long-term capital gains. The preferential treatment for capital gains has taken various forms including an exclusion of a fixed portion of the nominal gains, an exclusion that depended on the length of time a taxpayer held an asset, and a special maximum tax rate for capital gains. But at no time after 1921 and before 1987 were long-term capital gains ever taxed at the same rates as ordinary income.

By eliminating the capital gains exclusion and lowering tax rates on ordinary income, the 1986 Act increased the incentives for short-term trading of capital assets. This occurred because the tax rate on long-term capital gains was increased while the tax rate on short-term capital gains was reduced. By providing for a sliding scale exclusion that provides full benefits only for investments held at least 3 years after a phase-in period, the proposal will reduce the incentive for short-term trading.

The Cost of Capital and International Competitiveness. The capital gains tax is an important component of the cost of capital, which measures the pre-tax rate of return required to induce businesses to undertake new investment. Evidence suggests that the cost of capital in the United States is higher than that in many other industrial nations. While not solely responsible for the higher cost of capital, high capital gains tax rates hurt the ability of U.S. firms to obtain the capital needed to remain competitive. By reducing the cost of capital, a reduction in the capital gains tax rate will stimulate productive investment and create new jobs and growth.

Our major trading partners already recognize the economic importance of low tax rates on capital gains. Virtually all other major industrial nations provide lower tax rates on capital gains (or do not tax capital gains at all). Canada, France, Germany, Japan, the Netherlands, and the United Kingdom (among others), all treat capital gains preferentially.

According to a recent study by a Boston Federal Reserve Bank economist, the increase in the capital gains tax rate under the Tax Reform Act of 1986 increased the cost of capital to corporations by 8 percent.[2] This increase in the cost of capital tends to discourage capital formation and to misallocate resources away from productive business investments. This study concluded that in the long run, corporate capital would decline by as much as 5½ percent because of the capital gains tax induced increase in the cost of capital. This adverse effect of the higher cost of equity capital has a disproportionately large effect on new corporations. Another undesirable side effect of the increase in the capital gains tax was to increase the advantage of debt over equity finance.

The Lock-In Effect. Under a tax system in which capital gains are not taxed until realized by the taxpayer, a substantial tax on capital gains tends to lock taxpayers into their existing investments. Many taxpayers who would otherwise prefer to sell their assets to acquire new and better investments may instead continue to hold onto the assets, rather than pay the current high capital gains tax on their accrued gains.

This lock-in effect of capital gains taxation has at least three adverse effects. First, it produces a misallocation of the nation's capital stock and entrepreneurial talent, because it alters the investment decisions that would be made in a genuinely free market. For example, the lock-in effect reduces the ability of entrepreneurs to withdraw from an enterprise and use the funds to start new ventures. Productivity in the economy suffers because entrepreneurs are less likely to move to where they can be most productive, and because economic resources may be used in a less productive fashion rather than transferred to other, more efficient, enterprises. These effects can be especially critical for smaller firms, which may not have good access to capital markets and where ownership and operation frequently go together.

Second, the lock-in effect produces distortions in the investment portfolios of individual taxpayers. For example, some individual investors may be induced to assume

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[2] Yolanda Henderson, "Capital Gains Taxation and the Cost of Capital for Mature and Emerging Corporations," Unpublished Paper, October 1989.

more risk than they desire because they are reluctant to sell appreciated investments to diversify their portfolios.

Third, the lock-in effect reduces government receipts. To the extent that taxpayers defer sales of existing investments, or hold onto investments until death, taxes that might otherwise have been paid are deferred or avoided altogether. Therefore, individual investors, the government, and other taxpayers lose from the lock-in effect. The investor is discouraged from pursuing more attractive investments and the government loses revenue.

Substantial evidence from more than a dozen studies demonstrates that high capital gains tax rates in previous years produced significant lock-in effects. The importance of the lock-in effect may also be demonstrated by the fact that realized capital gains were 16 percent lower under the high tax rates in 1987 than under the lower rates in 1985, even though stock prices had risen by approximately 50 percent over this period. The high tax rates on capital gains under current law imply that the lock-in effect is greater than at any prior time.

Penalty on High Risk Investments. Full taxation of capital gains, in combination with limited deductibility of capital losses, discourages risk taking. It therefore impedes investment in emerging high-technology and other high-growth firms. While many investors are willing to take risks in anticipation of an adequate return, fewer are willing to contribute "venture capital" if a significant fraction of the increased reward will be used merely to satisfy higher tax liabilities. A tax system that imposes a high tax rate on gains from the investment reduces the attractiveness of risky investments, and may result in many worthwhile projects not being undertaken.

In particular, it is inherently more risky to start new firms and invest in new products and processes than to make incremental investments in existing firms and products. It is therefore the most dynamic and innovative firms and entrepreneurs that are the most disadvantaged by the current high capital gain tax rates that penalize risk taking. Such firms have traditionally been contributors to America's edge in international competition and have provided an important source of new jobs.

Double Tax on Corporate Stock Investments. Under the U.S. income tax system, income earned on investments in corporate stock is generally subjected to two layers of tax. Income on corporate investments is taxed first at the corporate level at a rate of 34 percent. Corporate income is taxed a second time at the individual level in the form of taxes on capital gains and dividends at rates ranging from 15 to 33 percent. The combination of corporate and individual income taxes thus can produce effective tax rates that are substantially greater than individual income tax rates alone. To the extent the return to the investor is obtained through appreciation in the value of the stock (rather than through dividend income), a reduction in capital gains tax rates provides a form of relief from this double taxation of corporate income. While a lower capital gains tax rate reduces the cost of capital for both corporate and noncorporate business, the greater liquidity of shares in publicly-traded companies suggests that the overall effect would be to reduce the bias towards noncorporate business that results from our dual-level tax system.

Inflationary Gains. Although inflation has been kept low under policies of the last 8 years, even low rates of inflation mean that individuals who sell capital assets at a nominal profit are paying tax on a fictional element of profit that represents only inflation. High rates of inflation, such as those that existed in the mid and late 1970's exacerbate the problem. Current law taxation of nominal capital gains at the full rates applicable to ordinary income has the inequitable result of producing unintended high tax rates on real (inflation-adjusted) capital gains that exceed the tax rates on ordinary income. This taxation of inflationary capital gains has particularly been a problem for lower and middle-income taxpayers with capital gains. However, adjusting directly for inflation through indexation would greatly complicate income tax returns and raise a number of difficult technical problems with respect to pass-through entities. The Administration proposal for a sliding scale exclusion provides a rough adjustment for the effects of inflation without creating the complexities and additional recordkeeping that a precise inflation adjustment would require.

Tax Shelters. Some claim that a lower rate for capital gains will threaten tax reform and result in a new proliferation of tax shelters. Prior to tax reform, 60 percent of long-term capital gains on assets held at least 6 months were excluded. Under the new Administration proposal, the maximum exclusion rate is 30 percent. Because of the smaller exclusion rate, depreciation recapture, and the alternative minimum tax, there is little danger of a resurgence of tax shelters. In addition,

other rule changes under tax reform, such as the limits on the deduction of passive losses, also protect the tax system against tax shelter abuses.

Complexity. Some suggest that adopting a preferential rate for capital gains will complicate the business and investment tax system. However, the distinction between capital and ordinary income was kept in the Internal Revenue Code for the purpose of limiting capital losses and in anticipation of a return of a preferential rate. The IRS has also retained tax forms for almost all reporting requirements with respect to capital gains, such as Schedule D (Capital Gains and Losses) and Form 4797 (Sales of Business Property).

Holding Periods. In developing the proposal, the Administration sought to balance its concern about locking taxpayers into their investments against its desire to discourage short-term investment strategy. Accordingly, the proposal ties increases in the capital gain exclusion rate to the period an asset is held in order to give taxpayers an incentive to hold their assets longer. Taxpayers will be entitled to a maximum 30 percent exclusion if they hold their assets for at least 3 years. Any lock-in effect is modified, however, because taxpayers will still be entitled to an exclusion (albeit smaller) for shorter holding periods down to 1 year.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will raise $4.9 billion in FY 1991 and $12.5 billion from FY 1990 through FY 1995. The Joint Committee on Taxation estimates that the proposal will raise $3.2 billion in FY 1991 but lose $11.4 billion from FY 1990 through FY 1995.

FAMILY SAVINGS ACCOUNTS

Description of the Proposal

The Family Savings Account (FSA) proposal will allow nondeductible contributions to an FSA of up to $2,500 per taxpayer with a maximum of two accounts per family. Contributions will be allowed for single people with adjusted gross incomes (AGIs) below $60,000, for those filing as heads of households with AGIs below $100,000, and for married couples filing joint returns with AGIs below $120,000. These contributions will be allowed in addition to contributions to qualified pension plans, IRAs, 401(k) plans, and other tax-favored savings plans.

Earnings on contributions retained in the FSA for at least 7 years will be eligible for full tax exemption upon withdrawal. However, withdrawals of earnings allocable to contributions retained in the FSA for less than 3 years will be subject to both a 10 percent excise tax penalty and to income tax. Withdrawals of earnings allocable to contributions retained in the FSA for 3 to 7 years will be subject only to income tax. The effective date will be January 1, 1990.

The effect of the proposal will be to increase the total amount of individual saving that can earn tax free investment income. Generally, individuals will be able to contribute to FSAs, IRAs, 401(k) plans, and similar tax-favored plans and receive tax exemption on the investment income from each source.

The ability to contribute to an FSA will significantly raise the total amount of allowable contributions to tax-favored savings accounts. The contribution limit is $5,000 for joint return filers as compared to the $4,000 IRA limit for a working couple with sufficient compensation. These higher total contribution limits will provide additional marginal incentives for personal saving. The higher eligibility limits on FSAs also expand the incentives to more taxpayers.

Despite the difference in structure, the value of the tax benefits in present value of an FSA per dollar of contribution is equivalent in terms of its tax treatment to the value of current law deductible IRAs, assuming that tax rates are constant over time. Both FSAs and deductible IRAs effectively exempt all investment income from tax. The contributions to FSAs are not deductible, but the income tax imposed on withdrawals from an IRA effectively offsets the tax savings from the deduction of the contribution (plus interest on the tax savings). Individuals who expect higher tax rates when the funds are withdrawn will generally prefer the tax treatment offered in an FSA to that in an IRA. Conversely, individuals who expect lower future tax rates will generally prefer an IRA as a vehicle for retirement savings. However, the FSA offers more flexibility, because full tax benefits are available 7 years after contribution and the account need not be held until retirement. This gives individuals an added degree of liquidity.

Reasons for the Proposal

The Administration is concerned that the rate of national saving and investment is too low relative to that needed to sustain future growth and to maintain our relative economic position in comparison with the performance of other industrial na-

tions. Addressing this problem requires that both public dissaving (the budget deficit) be reduced, and that private saving be increased. Incentives provided by the proposed FSA will provide an important incentive to encourage private saving.

The availability of tax-exempt savings accounts in the form of IRAs was sharply curtailed by the Tax Reform Act of 1986. This resulted in a large decline in IRA participation. Prior to the Act, any individual under the age of 70-1/2 could make deductible contributions, up to the current limits, to an IRA. One of the goals of the current proposal is to restore, and in several ways expand, the availability and attractiveness of tax-exempt saving to a large segment of the population.

An additional goal of the current proposal is to expand savings incentives to income that is saved for other than retirement purposes, while not eroding incentives for retirement saving. The proposal recognizes that individuals save for many reasons: for down payments on homes, for educational expenses, for large medical expenses, and as a hedge against uncertain income in the future.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will lose $200 million in FY 1991 and $4.7 billion from FY 1990 through FY 1995. The Joint Committee on Taxation estimates that the proposal will lose $300 million in FY 1991 and $5 billion from FY 1990 through FY 1995.

PENALTY-FREE IRA WITHDRAWALS FOR FIRST-TIME HOME BUYERS

Description of the Proposal

Under current law, married taxpayers who do not participate in a qualified retirement plan or who have adjusted gross incomes below $50,000 may make deductible contributions to an Individual Retirement Account (IRA). There is a lower threshold of $35,000 for unmarried taxpayers and for married taxpayers who file a separate return. The deductibility of contributions for taxpayers participating in a qualified retirement plan is phased out over the last $10,000 below the income threshold for each income tax filing status. Taxpayers who participate in a qualified retirement plan and have adjusted gross incomes above these thresholds may make only nondeductible contributions to an IRA. Both deductible and nondeductible IRA contributions are limited to the lesser of $2,000 or the individual's compensation for the year. Married individuals may contribute an additional $250 to a spousal IRA for a nonworking spouse.

Withdrawals from IRAs must begin by age 70½. IRA withdrawals, except those from nondeductible contributions, are subject to income tax. Withdrawals from an IRA prior to age 59½ are subject to a 10 percent additional tax.

To encourage home purchases without discouraging savings, the Administration proposes that individuals be allowed to withdraw amounts of up to $10,000 from their IRAs for a "first-time" home purchase. The 10 percent additional tax on early withdrawals imposed under current law will be waived for eligible individuals. Eligibility for penalty-free withdrawals will be limited to individuals who did not own a home in the last 3 years and are purchasing or constructing a principal residence that costs no more than 110 percent of the median home price in the area where the residence is located. The effective date of the proposal is January 1, 1990.

Reasons for the Proposal

The intent of this proposal is to expand savings incentives to income that is saved for first-time home purchases. Increased flexibility of IRAs would help to alleviate the difficulties that many individuals have in purchasing a new home.

The attractiveness of IRAs for many taxpayers was sharply curtailed by changes made by the Tax Reform Act of 1986 which resulted in a large decline in IRA participation. Prior to the Act, any individual under the age of 70-1/2 could make deductible contributions, up to the current limits, to an IRA. The current proposal is designed to enhance the attractiveness of deductible IRAs by making them more flexible. This increased flexibility will provide an incentive for more taxpayers to save for the purchase of their home.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will lose less than $50 million in FY 1991 and $400 million from FY 1990 through 1995. The Joint Committee on Taxation estimates that the proposal will lose $200 million in FY 1991 and $900 million from FY 1990 through FY 1995.

PERMANENT RESEARCH AND EXPERIMENTATION TAX CREDIT

Description of the Proposal

Present law allows a 20 percent tax credit (the R&E credit) for a certain portion of a taxpayer's qualified research expenses. The R&E credit is in effect for taxable years beginning after December 31, 1989. However, the credit will not apply to amounts paid or incurred after December 31, 1990, and a special rule applies in the case of any taxable year which begins before August 2, 1990, and ends after September 30, 1990. Under this rule, the amount treated as a taxpayer's qualified research expenses for the taxable year is pro-rated by the ratio of the number of days in the taxable year before October 1, 1990, to the total number of days in the taxable year before January 1, 1991. By limiting the amount of eligible expenses, this rule is intended to provide the equivalent of a 9 month extension of the R&E credit.

The Administration proposes that the R&E credit be made permanent, and that the special tax rule which limits the amount of eligible expenses during 1990 be eliminated.

Reasons for the Proposal

The R&E credit provides an incentive for technological innovation. Although the benefit to the nation from such innovation is unquestioned, the market rewards to those who take the risk of research and experimentation may not be sufficient to support the level of research activity that is socially desirable. The credit is intended to reward those engaged in research and experimentation of unproven technologies.

The credit cannot induce additional R&E expenditures unless its future availability is known at the time firms are planning R&E projects and projecting costs. R&E activity, by its nature, is long term, and taxpayers should be able to plan their research activity knowing that the credit will be available when the research is actually undertaken. Thus, if the R&E credit is to have the intended incentive effect, it should be made permanent.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will lose $500 million in FY 1991 and $5.5 billion from FY 1990 through FY 1995. The Joint Committee on Taxation estimates that the proposal will lose $900 million in FY 1991 and $7 billion from FY 1990 through FY 1995.

RESEARCH AND EXPERIMENTATION EXPENSE ALLOCATION RULES

Description of the Proposal

The tax credit allowed for payments of foreign tax is limited to the amount of U.S. tax otherwise payable on the taxpayer's income from foreign sources. The purpose of this limitation is to prevent the foreign tax credit from offsetting U.S. tax imposed on income from U.S. sources. Accordingly, a taxpayer claiming a foreign tax credit is required to determine whether income arises from U.S. or foreign sources and to allocate expenses between such U.S. and foreign source income.

Under these limitation rules, an increase in the portion of a taxpayer's income determined to be from foreign sources will increase the allowable foreign tax credit. Therefore, taxpayers generally receive greater foreign tax credit benefits to the extent that their expenses are applied against U.S. source income rather than foreign source income.

Treasury regulations issued in 1977 described methods for allocating expenses between U.S. and foreign source income. Those regulations contained specific rules for the allocation of research and experimentation (R&E) expenditures, which generally required a certain portion of R&E expense to be allocated to foreign source income. Absent such rules, a full allocation of R&E expense to U.S. source income would overstate foreign source income, thus allowing the foreign tax credit to apply against U.S. tax imposed on U.S. source income and thwarting the limitation on the foreign tax credit.

Since 1981 these R&E allocation regulations have been subject to six different suspensions and temporary modifications by Congress. The Technical and Miscellaneous Revenue Act of 1988 ("TAMRA") adopted allocation rules which were in effect for only 4 months. For 20 months following the period when the TAMRA rules were in effect, R&E allocation was controlled by the 1977 Treasury regulations. The Budget Reconciliation Act of 1989 (the "1989 Act") subsequently reintroduced the TAMRA rules, once again on a temporary basis.

Under the R&E allocation rules enacted by TAMRA (and temporarily recodified by the 1989 Act), a taxpayer must allocate 64 percent of R&E expenses for research

conducted in the United States to U.S. source income and 64 percent of foreign-performed R&E to foreign source income. The remaining portion can be allocated on the basis of the taxpayer's gross sales or gross income. However, the amount allocated to foreign source income on the basis of gross income must be at least 30 percent of the amount allocated to foreign source income on the basis of gross sales.

Under the 1989 Act, these R&E allocation rules are effective for the taxpayer's first taxable year beginning after August 1, 1989 and before August 2, 1990; except that the rules apply only to the portion of R&E expenses treated (on an annualized basis) as having been paid or incurred during the first 9 months of that taxable year.

The Administration proposes to adopt on a permanent basis the R&E allocation rules which were first enacted by TAMRA and were re-enacted by the 1989 Act. The proposal would be effective for all taxable years beginning after August 1, 1990.

Reasons for the Proposal

Permanent R&E expense allocation rules are essential for U.S. companies to plan accurately the long-term costs of their R&E programs. After more than 10 years of instability, both the U.S. Government and the affected taxpayers have a strong interest in ending this controversy through the adoption of a fixed allocation system applicable to R&E.

In addition, as evidenced by its continued support for a permanent R&E credit, the Administration believes in the provision of tax incentives to increase the performance of U.S.-based research activities. The allocation rules in this proposal provide such an incentive. Although the proposal benefits only multinational corporations that are subject to the foreign tax credit limitation, it will provide an effective incentive with respect to such entities. By enhancing the return on R&E expenditures, the proposal promotes the growth of overall R&E activity as well as encouraging the location of such research within the United States.

Effects of the Proposal on Revenues

Both Treasury's Office of Tax Analysis and the Joint Committee on Taxation estimate that the proposal will lose $400 million in FY 1991 and $3.6 billion from FY 1990 through FY 1995.

ENERGY TAX INCENTIVES

Description of the Proposal

Current law provides incentives for domestic oil and gas exploration and production by allowing the expensing of intangible drilling costs ("IDCs") and the use of percentage depletion. These two incentives are subject to certain limitations and their benefits are included as preferences in the alternative minimum tax ("AMT"). The cost of injectants used in tertiary enhanced recovery projects may also be deducted. Current law does not provide any further tax incentives for either exploratory drilling or tertiary enhanced recovery techniques.

The Administration proposes four incentives to encourage exploration for new oil and gas fields and the reclamation of old fields. Two proposals would provide tax credits which would be phased out if the average daily U.S. wellhead price of oil is at or above $21 per barrel for an entire calendar year. Because future oil prices are expected to exceed this price at some point, these credits should be viewed as inherently temporary, rather than as permanent features of the tax system. The other two proposals would enhance the incentive effects of current energy tax law.

First, a temporary 10 percent tax credit would be allowed for the first $10 million of expenditures (per year, per company) on exploratory intangible drilling costs and a 5 percent credit would be allowed for the balance of exploratory drilling costs. This proposal would be effective for costs incurred on or after January 1, 1991.

Second, a temporary 10 percent tax credit, effective January 1, 1991, would be allowed for all capital expenditures on new tertiary enhanced recovery projects (i.e., projects that represent the initial application of tertiary enhanced recovery to a property). These tax credits could be applied against both the regular tax and the alternative minimum tax. However, the credits, in conjunction with all other credits and net operating loss carryforwards, could not eliminate more than 80 percent of the tentative minimum tax in any year. Unused credits could be carried forward.

Third, the proposal would eliminate the "transfer rule," which limits percentage depletion to properties acquired by, or transferred to, an independent producer before the property is shown to have oil or gas reserves. The proposal also would increase the percentage depletion deduction limit for independent producers to 100 percent of the net income of each property. These changes would increase the avail-

ability to independent producers of the percentage depletion tax incentive. The effective date of each change would be January 1, 1991.

Fourth, the proposal would eliminate 80 percent of current AMT preference items generated by exploratory IDCs incurred by independent producers effective January 1, 1991. Thus, independent producers would be allowed to deduct 80 percent (rather than zero, as under current law) of exploratory excess IDCs in excess of the net income limit for purposes of the AMT. As under current law, the net income limit would be equal to 65 percent of oil and gas adjusted net income determined without regard to excess IDC deductions.

Reasons for the Proposal

The reduction in world oil prices and the increasing levels of oil imports over the last several years raise energy security concerns. While oil prices appear more recently to have firmed up, the nation's increased dependence on foreign oil still leaves the nation vulnerable to potential foreign supply disruptions. The Administration supports an energy policy that is designed to address these concerns by improving our long-term energy security and strengthening the domestic oil industry.

An increase in domestic oil and gas reserves would improve energy security. The level of proven domestic reserves is closely related to the level of domestic exploratory drilling, which has fallen by 70 percent from recent levels, largely due to uncertainty concerning low world oil prices. In addition, over the last several years, development drilling has increased 20 percent, resulting in a substantial decline in existing domestic oil and gas reserves. Special tax incentives are appropriate to encourage higher levels of exploratory drilling, which will ultimately may lead to increased domestic reserves.

Current law limits the incentive effects of IDC expensing and percentage depletion, particularly for independent producers, who have historically drilled a majority of exploratory wells. Current percentage depletion rules limit its use to properties acquired by, or transferred to, an independent producer before the property is shown to have oil or gas reserves (the "transfer rule"). This rule discourages the transfer of producing wells that are uneconomic in the hands of their current owners (and thus likely to be abandoned) to those who may be more efficient, more willing to bear current losses, or better able to use the depletion tax benefits (and thus able to continue operation of the property). By keeping marginal wells in production, U.S. oil production would be maintained without incurring additional drilling costs and wells can be kept available for possible future enhanced recovery effects.

Current law also provides that percentage depletion may not exceed 50 percent of the net income of a property calculated before depletion. The 50 percent net income limitation may significantly reduce the benefits of percentage depletion for production from properties generating a small amount of net income. Raising the net income limitation to 100 percent would allow some oil producers to claim greater depletion deductions, thus encouraging them to continue to operate marginal properties.

The current AMT also severely limits the incentive effects of IDC expensing, particularly for independent producers. Raising the net income limit and reducing the impact of the AMT on drilling incentives might also encourage added investment in exploratory drilling projects.

The level of exploratory drilling (and ultimately domestic reserves) would be increased by providing a program of temporary IDC credits, less restrictive rules for the use of percentage depletion, and AMT relief, all targeted to exploratory drilling in general, and to independent producers in particular. A temporary tax credit for new tertiary enhanced recovery projects would also encourage the recovery of known energy deposits that are currently too costly to produce and which would be lost if the wells are abandoned.

Effects of the Proposal on Revenues

Both Treasury's Office of Tax Analysis and the Joint Committee on Taxation estimate that (1) the tax credits for oil and gas exploration and tertiary recovery will lose $200 million in FY 1991 and $1.8 billion from FY 1990 through FY 1995; (2) the modification of oil and gas percentage depletion rules will lose less than $50 million in FY 1991 and $200 million from FY 1990 through FY 1995; and (3) the modification of the tax preference for IDCs in the alternative minimum tax will lose $100 million in FY 1991 and $500 million from FY 1990 through FY 1995.

ENTERPRISE ZONE TAX INCENTIVES

Description of the Proposal

Existing Federal tax incentives generally are not targeted to benefit specific geographic areas. Although the Federal tax law contains incentives that may encourage economic development in targeted economically distressed areas, the provisions generally are not limited to use with respect to such areas.

The Administration's enterprise zone initiative would provide selected Federal income tax employment and investment incentives for up to 50 zones selected over a 4 year period. These incentives will be offered in conjunction with Federal, state, and local regulatory relief.

The incentives are: (i) a 5 percent refundable tax credit for qualified employees with respect to their first $10,500 of wages earned in an enterprise zone (up to $525 per worker, with the credit phasing out between $20,000 and $25,000 of total annual wages of the employee); (ii) elimination of capital gains taxes for tangible property used in an enterprise zone business and located within an enterprise zone for at least 2 years; and (iii) expensing by individuals of contributions to the capital of corporations engaged in the conduct of enterprise zone businesses (provided the corporation has less than $5 million of total assets and uses the contributions to acquire tangible assets located within an enterprise zone, and limiting the expensing to $50,000 annually per investor with a $250,000 lifetime limit per investor).

The willingness of states and localities to "match" Federal incentives will be considered in selecting the special enterprise zones to receive these additional Federal incentives.

Reason for the Proposal

Despite sustained national prosperity and growth, certain areas have not kept pace. Enterprise zones would encourage private industry investment and job creation in economically distressed areas by removing regulatory and other barriers inhibiting growth. They would also promote growth through selected tax incentives to reduce the risks and costs of operating or expanding in severely depressed areas.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will lose $50 million in FY 1991 and $1.8 billion from FY 1990 through FY 1995. Neither the Joint Committee on Taxation nor Congressional Budget Office has estimated the revenue effects of this proposal.

NEW CHILD TAX CREDIT AND REFUNDABLE CHILD AND DEPENDENT CARE CREDIT

Description of the Proposal

The Internal Revenue Code currently provides assistance to low-income working parents through both the earned income tax credit (EITC) and the child and dependent care credit. It is widely agreed that these credits do not adequately provide for the child care needs of low-income families. Accordingly, the Administration has proposed a new or modified child care credit for low-income working families (in addition to the current law earned income credit).

New Child Tax Credit. Low-income families, containing at least one worker, would be entitled to take a new tax credit of up to $1,000 for each dependent child under age 4. For each child under the age of 4, families could receive a credit equal to 14 percent of earned income, with a maximum credit equal to $1,000 per child. Initially, the credit would be reduced by an amount equal to 20 percent of the excess of AGI or earned income (whichever is greater) over $8,000. As a consequence, the credit would not be available to families with AGI or earned income greater than $13,000. In subsequent years, both the starting and end-points of the phase-out range would be increased by $1,000 increments. In FY 1995, the credit would phase out between $15,000 and $20,000. Beginning in 1996, the income thresholds would be indexed for inflation.

The credit would be refundable and would be effective for tax years beginning after December 31, 1990. Families would have the option of receiving the refund in advance through a payment added to their paycheck.

Refundable Child and Dependent Care Credit. The existing child and dependent care credit would be made refundable (but otherwise unchanged). Families could not claim both the new child credit and the child and dependent care credit with respect to the same child but could choose the larger of the two credits. The refundable child care credit would be effective for tax years beginning January 1, 1991.

Reasons for the Proposal

For low-income families which rely on paid child care arrangements, child care expenditures consume a large share of their income. On average, child care expenditures constitute 6 percent of income for all families which paid for the care of their preschool children. But, for low-income families with working mothers, child care expenditures constitute about 20 percent of income. Further, because the child and dependent care credit is not refundable, many low-income families cannot claim the credit since they do not incur a Federal income tax liability.

In addition, child care by relatives—much of which is not paid for in cash—is especially prevalent among low-income families. Over half of low-income families with preschool children do not make cash expenditures and could not benefit from the child and dependent care credit, even if it was refundable.

The EITC, while refundable, does not adjust for differences among working families in the costs of providing care according to the age of the dependent child or the number of dependent children. Preschool children generally require more extensive child care services than older children who may be in a school setting for much of the day.

The Administration's child care proposals will increase the resources available to low-income families, better enabling them to choose the child care arrangements which best suit their needs and correspond to their personal values. The child care proposal, combined with newly legislated increases in the minimum wage, will lift a single mother of two preschool children, who works full-time at the minimum wage, above the poverty level.

About 2.2 million working families with children under the age of 4 will initially be eligible for the new child tax credit. When the proposal is fully implemented, eligibility will be expanded to approximately 1 million additional families. These families will also have the option of claiming the refundable child and dependent care credit, although they will not be able to claim both credits with respect to the same child. In addition, low-income parents of children between the ages of 4 and 12 would benefit from the refundability of the child and dependent care credit if they incur child-care expenses in order to work.

Consider, for example, a single mother of two children, ages 3 and 6. The mother earns $10,000 a year and has no other sources of taxable income. She pays a neighbor $20 a week to care for her younger child. Her older child is enrolled in a after-school program during the winter months and a neighborhood park program during the summer at a total cost of $500 per year. In total, she spends $1,540 a year for child care in order to work. Under current law, she is not entitled to claim the child and dependent care credit. At a 30 percent credit rate on dependent care expenses, the credit would be $462. However, she has no tax liability as a consequence of the standard deduction and personal exemptions and therefore cannot claim the credit.

Under the proposal, the mother will be able to claim the new child credit. In 1991, she will be entitled to a credit equal to $600. (A mother in similar circumstances in 1993 would be entitled to the full $1,000 credit.) In addition, the mother will be able to claim a refundable child and dependent care credit of $150 on the basis of the expenses associated with the day care of her older child. In total, she will be entitled to an additional refund of $750. Under both current law and the proposed changes, she will also receive an EITC of about $990, bring her total 1991 refund under the proposal to $1,740.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will lose less than $50 million in FY 1991 and (at most) $250 million from FY 1990 through FY 1995. The Office of Tax Analysis also estimates that increased outlays attributable to refunds payable to eligible individuals with no tax liability will be $200 million in 1991 and $8.3 billion from FY 1990 through FY 1995.

The Joint Committee on Taxation estimates that the proposal will lose less than $50 million in FY 1991 and $900 million from FY 1990 through FY 1995.

DEDUCTION FOR SPECIAL NEEDS ADOPTIONS

Description of the Proposal

Expenses associated with the adoption of children are not deductible under current law. However, expenses associated with the adoption of special needs children are reimbursable under the Federal-State Adoption Assistance Program (Title IV–E of the Social Security Act). Special needs children are those who by virtue of special conditions such as age, physical or mental handicap, or combination of circumstances, are difficult to place for adoption. The Adoption Assistance Program in-

cludes several components. One of these components requires states to reimburse families for costs associated with the process of adopting special needs children. The Federal Government shares 50 percent of these costs up to a maximum Federal share of $1,000 per child. Reimbursable expenses include those associated directly with the adoption process such as legal costs, social service review, and transportation costs. Some children are also eligible for continuing Federal-State assistance under Title IV-E of the Social Security Act. This assistance includes Medicaid. Other children may be eligible for continuing assistance under State-only programs.

The Administration proposes to permit the deduction from income of expenses incurred associated with the adoption of special needs children up to a maximum of $3,000 per child. Eligible expenses would be limited to those directly associated with the adoption process that are eligible for reimbursement under the Adoption Assistance Program. These include court costs, legal expenses, social service review, and transportation costs. Only expenses for adopting children defined as eligible under the rules of the Adoption Assistance Program would be allowed. Expenses which were deducted and reimbursed would be included in income in the year in which the reimbursement occurred.

Reasons for the Proposal

The Tax Reform Act of 1986 (the "1986 Act") repealed the deduction for adoption expenses associated with special needs children. Under prior law, a deduction of up to $1,500 of expenses associated with the adoption of special needs children was allowed. The 1986 Act provided for a new outlay program under the existing Adoption Assistance Program to reimburse expenses associated with the adoption process of these children. The group of children covered under the outlay program is somewhat broader than the group covered by the prior deduction. The prior law deduction was available only for special needs children assisted under Federal welfare programs (Aid to Families with Dependent Children (AFDC), Title IV-E Foster Care, or Supplemental Security Income (SSI)). The current adoption assistance outlay program provides assistance for adoption expenses for these special needs children, as well as special needs children in private and State-only programs.

Repeal of the special needs adoption deduction may have appeared to some as a lessening of the Federal concern for the adoption of special needs children.

An important purpose of the Adoption Assistance Program is to enable families in modest circumstances to adopt special needs children. In a number of cases the children are in foster care with the prospective adoptive parents. The prospective parents would like to formally adopt the child but find that to do so would impose a financial hardship on the entire family.

While the majority of eligible expenses are expected to be reimbursed under the continuing expenditure program, the Administration is concerned that in some cases the limits may be set below actual cost in high-cost areas or in special circumstances. Moreover, inclusion in the tax Code of a deduction for special needs children may alert families who are hoping to adopt a child to the many forms of assistance provided to families adopting a child with special needs.

The proposal when combined with the current outlay program would assure that reasonable expenses associated with the process of adopting a special needs child do not cause financial hardship for the adoptive parents. The proposed deduction would supplement the current Federal outlay program. In addition, the proposal highlights the Administration's concern that adoption of these children be specially encouraged and may call to the attention of families interested in adoption the various programs that help families adopting children with special needs.

Effects of the Proposal on Revenues

Both Treasury's Office of Tax Analysis and the Joint Committee on Taxation estimate that the proposal will lose less than $50 million in FY 1991 and (at most) $250 million from FY 1991 through FY 1995.

LOW-INCOME HOUSING TAX CREDIT

Description of the Proposal

Under current law, a tax credit is allowed for certain expenditures with respect to low-income residential rental housing. The low-income housing credit generally may be claimed by owners of qualified low-income buildings in equal annual installments over a 10 year credit period as long as the buildings continue to provide low-income housing over a 15 year compliance period.

In general, the discounted present value of the installments may be as much as 70 percent of eligible expenditures. Eligible expenditures include the depreciable costs of new construction and substantial rehabilitations, as well as the cost of acquiring

certain existing buildings not placed in service within the previous 10 years and not subject to the 15 year compliance period. The basis of property is not reduced by the amount of the credit for purposes of depreciation and capital gain.

The annual credit available for a building cannot exceed the amount allocated to the building by the designated State or local housing agency. As originally enacted, the total allocations by the housing agency in a given year could not exceed the product of $1.25 and the State's population. A State credit allocation is not required, however, for certain projects financed with tax-exempt bonds subject to the State's private activity bond volume limitation. While the credits originally could not be allocated after 1989, the Omnibus Budget Reconciliation Act of 1989 (OBRA) extended each State's credit allocation authority through 1990 at a level equal to the product of $0.9375 and the State's population.

The Administration proposes to extend the credit through 1991, and would establish each State's credit allocation authority for 1990 and 1991 at a level equal to the product of $1.25 and the State's population.

Reasons for the Proposal

The low-income housing credit encourages the private sector to construct and rehabilitate the nation's rental housing stock and to make it available to the working poor and other low-income families. In addition to tenant-based housing vouchers and certificates, the credit would appear to be an important mechanism for providing Federal assistance to rental households. Because the effectiveness of this newly designed incentive was unclear when introduced in the Tax Reform Act of 1986, it was felt appropriate to limit its availability. While extended by OBRA through 1990 (at a reduced limit), it is useful to allow a more extensive examination of this method of providing low income housing assistance.

Effects of the Proposal on Revenues

Both Treasury's Office of Tax Analysis and the Joint Committee on Taxation estimate that the proposal will lose $100 million in FY 1991 and approximately $1.7 billion from FY 1990 through FY 1995.

EXTEND SPECIAL RULES FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS

Description of the Proposal

Current law allows a self-employed individual to deduct as a business expense up to 25 percent of the amount paid during a taxable year for health insurance coverage for himself, his spouse, and his dependents. Originally, this deduction was only available if the insurance was provided under a plan that satisfied the non-discrimination requirements of section 89 of the Code. Section 89 has since been repealed retroactively, however, and no non-discrimination requirements currently apply to such insurance. The value of any coverage provided for such individuals and their families by the business is not deductible for self-employment tax purposes. The deduction is scheduled to expire after September 30, 1990. For taxable years beginning in 1990, the deduction is allowed only for premiums paid for coverage through October 1, 1990.

The Administration proposes that the 25 percent deduction be made permanent.

Reasons for the Proposal

The 25 percent deduction for health insurance costs of self-employed individuals was added by the Tax Reform Act of 1986 because of a disparity between the tax treatment of owners of incorporated and unincorporated businesses (*e.g.,* partnerships and sole proprietorships). Under prior law, incorporated businesses could generally deduct, as an employee compensation expense, the full cost of any health insurance coverage provided for their employees (including owners serving as employees) and their employees' spouses and dependents. By contrast, self-employed individuals operating through an unincorporated business could only deduct the cost of health insurance coverage for themselves and their spouses and dependents to the extent that it, together with other allowable medical expenses, exceeded 5 percent of their adjusted gross income. (Coverage provided to employees of the self-employed, however, was and remains a deductible business expense for the self employed.) The special 25 percent deduction was designed to mitigate this disparity in treatment.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will lose $200 million in FY 1991 and $2.25 billion from FY 1990 through FY 1995. The Joint Committee on Taxation estimates that the proposal will lose $400 million in FY 1991 and $2.7 billion from FY 1990 through FY 1995.

EXTEND SOCIAL SECURITY RETIREMENT COVERAGE TO STATE AND LOCAL EMPLOYEES NOT PARTICIPATING IN PUBLIC EMPLOYEE RETIREMENT PROGRAMS

Description of the Proposal

State and local government employees are not required to participate in Social Security (OASDI). Approximately 70 percent of State and local government employees are covered under Social Security through voluntary agreements between the Secretary of Health and Human Services and with State or local government entity. The State and local governments decide, within the framework of Federal and state law, which groups of employees to cover and when coverage is to begin under Social Security. State and local governments also determine which groups of employees to cover under their own public retirement programs.

The Administration proposes that effective October 1, 1990, mandatory Social Security coverage be extended to those employees of State and local governments who do not participate in a retirement program in conjunction with their current employment.

Reasons for the Proposal

State and local government employment is the only major job category not required to participate in Social Security. About one-third (7 million) of the workers employed by State and local governments during a year are not in jobs covered by Social Security agreements. Of these, over half (3.8 million) are also not covered by a State or local government retirement program.

Extending coverage would provide valuable Social Security retirement, survivor, and disability protection to state and local government employees most in need of it—those without any protection under a State or local government retirement program. Without Social Security protection, uncovered state and local workers and their families are vulnerable to unexpected tragic events, like disability or death of a wage earner. As a result, the families could become dependent on Federal and State welfare assistance. Therefore, the HHS Inspector General recommended extending coverage to these workers in a 1987 report.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that this proposal will raise $2.1 billion in FY 1991 and $11.8 billion from FY 1990 through FY 1995. The Congressional Budget Office is expected to release its estimate of this proposal on March 7.

MEDICARE HOSPITAL INSURANCE (HI) FOR STATE AND LOCAL EMPLOYEES

Explanation of the Proposal

As a consequence of the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA), State and local government employees hired on or after April 1, 1986, are covered by Medicare Hospital Insurance (HI), and their wages are subject to the HI tax. The tax is equal to 1.45 percent of wages—currently up to a maximum of $51,300—and is paid by both the employer and employee. Employees hired prior to April 1, 1986, are not subject to the HI tax unless they are employed by a state which has a voluntary coverage agreement with the Social Security Administration.

The Administration proposes that as of October 1, 1990, all State and local government employees be covered by HI regardless of date of employment.

Reasons for the Proposal

State and local government employees are the only major group of employees not contributing to HI. Approximately 10 percent (2.4 million) of State and local government employees are not covered by voluntary agreements or by COBRA. Yet, a 1989 study by the HHS Inspector General finds that nearly 85 percent of the noncontributing State and local government employees will receive Medicare benefits based on either spousal entitlement or periods of work in covered employment. Extending coverage would eliminate the inequity and the drain on the Medicare Trust Fund caused by those who receive Medicare without fully contributing. Further, this proposal would assure access to the minority of State and local government employees who would otherwise not be entitled to Medicare benefits.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will raise $1.7 billion in FY 1991 and $8.4 billion from FY 1990 through FY 1995. The Congressional Budget Office is expected to release its estimate of this proposal on March 7.

AIRPORT AND AIRWAY TRUST FUND

Description of the Proposal

The Airport and Airway Trust Fund supports the capital and operating programs of the Federal Aviation Administration (FAA). The Trust Fund receives revenue from taxes imposed on users of the nation's air transportation system. These taxes include the 8 percent air passenger tax, the 5 percent air freight tax, the 12 cents per gallon noncommercial aviation gasoline tax, and the 14 cents per gallon noncommercial aviation jet fuel tax. In addition, the Trust Fund receives revenue from the international air departure tax, which was increased from $3 to $6 by the Omnibus Budget Reconciliation Act of 1989 (OBRA). The Airport and Airway Trust Fund taxes are scheduled to expire after 1990.

OBRA suspended for 1 year a trigger that would reduce several of the Airport and Airway Trust Fund taxes. The trigger would also take effect after 1990 if the appropriations in fiscal years 1989 and 1990 for capital programs funded by these taxes are less than 85 percent of authorizations. The trigger would reduce by 50 percent both the air passenger tax and the air freight tax, and it would substantially reduce the aviation gasoline tax.

Under Gramm-Rudman-Hollings, the current services budget includes the extension of excise tax trust fund receipts and outlays at the levels in effect during the budget year. As a consequence, the 1991 budget baseline includes the extension of the Airport and Airway Trust Fund tax rates at their current levels irrespective of the trigger. The actual realization of Airport and Airway Trust Fund tax receipts at current services levels would require an extension of the taxes at their current rates (which implies a repeal of the trigger).

The Administration proposes to raise the air passenger tax to 10 percent, the air freight tax to 6 percent, the noncommercial aviation gasoline tax to 15 cents per gallon, and the noncommercial jet fuel tax to 18 cents per gallon. However, the proposal would not affect the international air departure tax.

Reasons for the Proposal

The Airport and Airway Development and Revenue Act of 1970 established the Airport and Airway Trust Fund as a mechanism for financing the capital and operating programs of the FAA through taxes imposed on the users of the nation's air transportation system. The Airport and Airway Trust Fund taxes have never covered total FAA outlays and, in fact, are projected to cover only 60 percent of total FAA outlays in 1990.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will raise $500 million in FY 1991 and $4.1 billion from FY 1990 through FY 1995. The Congressional Budget Office is expected to release its estimate of this proposal on March 7.

EXTENSION OF THE COMMUNICATIONS (TELEPHONE) EXCISE TAX

Description of the Proposal

The Omnibus Budget Reconciliation Act of 1987 extended the communications excise tax until December 31, 1990. The tax is imposed at a rate of 3 percent on local and toll telephone service and on teletypewriter exchange service.

The Administration proposes to extend permanently the 3 percent communications excise tax. The tax rate is substantially less than the 10 percent rate that was in effect between 1954 and 1972, and as low or lower than the rate in effect for any year since 1932 (except for 1980–82). The base of the tax would not be broadened.

Reasons for the Proposal

The communications excise tax was originally enacted in 1914 and has been imposed continuously since 1932, even though it has been scheduled to expire continuously since 1959. Allowing the tax to expire will reduce Federal tax receipts by approximately $2.5 billion annually at 1992 levels.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will raise $1.5 billion in FY 1991 and $12.7 billion from FY 1990 through FY 1995. The Congressional Budget Office is expected to release its estimate of this proposal on March 7.

TREATMENT OF SALVAGE VALUE BY PROPERTY AND CASUALTY INSURANCE COMPANIES

Description of the Proposal

The Administration proposes requiring that when property and casualty insurers deduct losses which they have incurred, the deduction be reduced by estimated recoveries of salvage attributable to such losses, regardless of how states treat salvage for state reporting purposes.

Under current law, property and casualty insurers may deduct from underwriting income losses incurred. Section 832(b)(5) provides that losses incurred are generally computed by deducting from losses paid any increase in salvage and reinsurance recoverable attributable to such losses, and adding to that amount any increase in reserves for losses incurred during the taxable year, but still unpaid at year's end.

Although the statute clearly requires that paid losses be reduced to take into account salvage recoverable, this reduction generally has not been made because prior regulations provided that companies were not required to reduce paid losses by estimated salvage recoveries if any state in which the taxpayer transacted business prohibited the taxpayer from treating the salvage as an asset for state reporting purposes. Several states have rules prohibiting the reporting of any salvage not reduced to cash or cash equivalents.

Current law also requires that the part of the deduction for "losses incurred" that represents losses unpaid at the end of the taxable year must comprise only actual unpaid losses. These unpaid losses must be based on a fair and reasonable estimate of the amount the company will be required to pay.

In general, the Administration's proposal would require that salvage and reinsurance recoverable attributable to paid losses must be taken into account as a reduction to such paid losses. Further, in making a fair and reasonable estimate of losses unpaid, companies would be required to take into account estimated recoveries of salvage and reinsurance attributable to such unpaid losses. Treasury would be given regulatory authority to provide for the discounting of any salvage to be taken into account.

The proposal would apply to taxable years beginning after December 31, 1989. Application of the proposal would be treated as a change in the taxpayer's method of accounting, and any adjustment to income required as a result of such change would be spread over a period not exceeding 4 years. In all cases, the amount of the adjustment would be the difference between the amount of unreduced loss reserves at the end of the taxable year immediately preceding the first taxable year beginning in 1990, and the amount of the unreduced loss reserve determined under this proposal as of the beginning of the first taxable year beginning in 1990.

Reasons for the Proposal

In 1988, the Treasury issued temporary and proposed regulations to require that property and casualty insurance companies reduce their deduction for losses incurred by estimated salvage recoveries, whether or not the salvage is treated as an asset for state reporting purposes. The industry subsequently raised concerns about the authority of the Treasury to issue these regulations. As a result, the effective date of the regulations has been postponed.

Whether the temporary and proposed regulations are valid under current law is a complicated issue involving many factors. While we believe that the Treasury has the authority to issue these regulations, we recognize the possibility that, after many years of litigation, the issue may not be resolved in our favor. We have no doubt, however, that the policy underlying the regulations is correct. The state rules prohibiting the reporting of any salvage not reduced to cash or cash equivalents reflect the generally conservative nature of state reporting measures, which are designed to ensure the solvency of insurance companies. The exclusion of a significant amount of salvage, while consistent with state regulatory ends, does not result in an accurate measurement of income for Federal tax purposes. A more accurate measure can be achieved by requiring the matching of expected salvage recoveries against incurred losses.

The Administration's proposal would confirm our authority to require companies to net salvage against their loss deductions and, thus, prevent companies from overstating deductions taken for underwriting losses.

Effects of the Proposal on Revenues

Both Treasury's Office of Tax Analysis and the Joint Committee on Taxation estimate that the proposal will raise $200 million in FY 1991 and $1.1 billion from FY 1990 through FY 1995.

PAYROLL TAX DEPOSIT STABILIZATION

Description of the Proposal

Under current law, employers deposit income taxes and FICA (social security) taxes withheld from employees' wages together with the employers' matching shares of FICA taxes. The frequency of payment is related to the amount of unpaid liability.

Smaller employers pay accumulated payroll tax liabilities of $500 or more after the end of the month; payroll tax liabilities under $500 are paid after the end of each calendar quarter.

Until August 1990, larger employers are required to deposit payroll taxes as frequently as 8 times a month. Employers who have $3,000 or more of accumulated but undeposited payroll taxes at the end of eighth-monthly periods (periods which end on the 3rd, 7th, 11th, 15th, 19th, 22nd, 25th, and last days of each month) are required to deposit at least 95 percent of such taxes within 3 banking days. The remainder is due with the first deposit otherwise required after the 15th of the following month.

Beginning in August 1990, under provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA), payment of accumulated liabilities of $100,000 or more will be accelerated and deposits may be required more frequently than 8 times a month. An employer who is on the eighth-monthly deposit system will be required to deposit at least 95 percent of accumulated payroll taxes by the close of the next banking day after any day on which the employer has undeposited payroll taxes accumulated within that eighth-monthly period of $100,000 or more, regardless of whether that day is the last day of an eighth-monthly period.

From August 1990 through December 1990, accumulated, unpaid payroll taxes of $100,000 or more trigger a next banking day deposit requirement. During 1991, such amounts must be deposited by the second banking day. During 1992 and 1993, such amounts must be deposited by the third banking day. During 1994 and 1995, such amounts must again be deposited by the next banking day. After 1995, OBRA empowers the Treasury Department to issue regulations to set the deposit dates in a similar manner in order to minimize the unevenness of the receipts effects of the provision. It is anticipated that deposits would continue to be required on the next banking day.

The Administration proposes that an employer who is on the eighth-monthly deposit system be required to deposit at least 95 percent of accumulated payroll taxes by the close of the next banking day after any day on which the employer had undeposited payroll taxes accumulated within that eighth-monthly period of $100,000 or more, regardless of whether that day is the last day of an eighth-monthly period. The proposal would become effective for payroll tax deposits beginning in August 1990.

Reasons for the Proposal

Most payroll taxes are withheld from the wages and salaries of employees and are held by employers as agents for the U.S. Government. The delay between the payroll date and the date on which the withheld taxes are paid to the Treasury was originally intended to permit employers to verify the amount of payroll tax liability and to minimize the administrative burdens and processing costs of immediate payment for employers and the government.

In recent years, the advances in automated payroll and accounting equipment have virtually eliminated the need for any delay between the payroll date and the date on which the taxes are deposited by the employer. In recognition of this, Congress in OBRA required many employers to make deposits on the next banking day after they have accumulated undeposited payroll taxes of $100,000 or more. This change is effective for amounts required to be deposited after July 31, 1989.

However, this change was not made permanent. Instead the 1 day delay applies only in 1990, and then automatically shifts to 2 days in 1991, to 3 days in 1992, and then back to 1 day in 1993 and 1994. After 1994, the Secretary of the Treasury is directed to issue regulations which "minimize the unevenness" in the revenue effect of the provision.

The automatic shift from 1 to 2 days in 1991, and from 2 to 3 days in 1992, is inconsistent with the rationale which Congress gave for the change which it made in 1989—that is, that advances in payroll systems make such delays unnecessary. Moreover, current law would place substantial burdens on employers who would be forced to reprogram their payroll system for 4 years in a row to take account of the shifting deposit dates.

The proposal would change the OBRA-mandated second banking day deposit requirement for 1991 and the third banking day deposit requirement for 1992 and 1993 to a next day deposit requirement. Under the proposal, the change to next banking day deposits imposed by OBRA and scheduled to become effective in August 1990 would be permanent and would be the only change required by employers.

The proposal to continue next banking day payroll tax deposits after 1990 would not impose any new burdens on affected employers. In fact, since much of the burden of payroll tax deposit requirements is from adjusting to changes, the current proposal will ease administrative burdens by eliminating the currently scheduled changes in deposit rules in 1991, 1992, and 1994.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal will raise $900 million in FY 1991 and $2.2 billion in FY 1992, but will exactly offset these gains with $3.1 billion in revenue losses in FY 1993. The Joint Committee on Taxation estimates that the proposal will raise $1 billion in FY 1991 and $2.2 billion in FY 1992, but will exactly offset these gains with $3.2 billion in revenue losses in FY 1993.

PERMIT LIMITED USE OF EXCESS PENSION FUNDS TO PAY RETIREE HEALTH BENEFITS

Description of the Proposal

Pension plan assets may not revert to an employer prior to termination of the plan and the satisfaction of all plan liabilities. Any assets that revert to the employer upon such termination are included in the gross income of the employer and are subject to a 15 percent excise tax.

A pension plan may provide medical benefits to retirees through a section 401(h) account that is part of such plan. The assets of a pension plan may not be transferred to a section 401(h) account without disqualifying the pension plan and subjecting the amounts transferred to income and excise taxes.

The Administration would allow the transfer of excess pension plan assets to a 401(h) account to pay current retiree health benefits without termination or disqualification of the plan. The amount of the transfer could not exceed the amount of assets in excess of 140 percent of the plan's current liability or, if less, the plan's current retiree health liabilities for the current year. Amounts transferred would not be includable in gross income or subject to the excise tax on reversions.

Transfers would be permitted on an interim basis only, thereby enabling policy makers to evaluate the effectiveness and the long-term revenue effects of this approach to satisfy retiree health liabilities.

There would be no requirement that employers purchase annuities for plan participants.

In the event of a transfer, the pension plan would be subject to additional requirements with respect to pension benefits, such as full vesting, to preserve benefit security. More specifically, only one transfer would be permitted. The transfer would have to occur before January 1, 1993 and in a plan year beginning after December 31, 1990.

Reasons for the Proposal

Many employers currently have substantially over-funded pension plans. At the same time, many of these employers are facing significant retiree health liabilities for which current law permits limited tax-favored pre-funding. The proposal would permit employers to use some portion of excess pension plan assets to satisfy current retiree health liabilities under the same plan.

Employers could be expected to transfer funds from the pension portion of an over-funded plan rather than making additional contributions to a 401(h) account under the same plan. Since additional contributions are deductible from income, taxable income would be increased in the short run. In the longer run, however, the reduction in assets available to pay pension benefits could result in a corresponding increase in contributions for that purpose.

Effects of the Proposal on Revenues

Treasury's Office of Tax Analysis estimates that the proposal, without an annuity requirement, will raise $324 million in FY 1991 and $1.2 billion from FY 1990 through FY 1995. The Joint Committee on Taxation estimates that the proposal will raise $300 million in FY 1991 and $1 billion from FY 1990 through FY 1995. However, the Joint Committee's estimates were made before the Administration clarified that there would be no requirement that employers purchase annuities for plan participants.

MISCELLANEOUS PROPOSALS AFFECTING RECEIPTS

Description of the Proposals

The Administration has proposed initiatives affecting budget receipts, such as:

(1) *Increase the District of Columbia (D.C.) employer contribution to the civil service retirement system (CSRS).* Effective January 1, 1991, the D.C. Government would be required to phase-in payments for current CSRS employee cost of living (COLAs) liabilities, as well as to pay the cost of COLAs for post-1986 CSRS annuitants.

(2) *Increase ad valorem fee on shippers.* The current ad valorem fee on shippers would be increased from .04 percent of cargo value to approximately 0.125 percent of cargo value. This increase would fully offset the cost of Corps of Engineers harbor maintenance dredging; currently 40 percent of the cost of the program is recovered by the fee. It would also offset the cost of certain National Oceanic and Atmospheric Administration marine programs, including coastal mapping, marine weather, and circulation and tide data.

(3) *Increase and expand Securities Exchange Commission (SEC)* fees. Effective July 1, 1990, the fee on securities market transactions would be increased from 1/300 to 1/220 of 1 percent of dollar volume traded, and would be extended to apply to most over-the-counter securities transactions. In addition, the fee charged for merger or proxy filing would be increased from 1/50 to 1/40 of 1 percent of the value of the transaction. Similarly, the registration fee on securities offerings would be increased from 1/50 to 1/40 of 1 percent of the value of the offering.

(4) *Modify collection period of telephone excise tax.* Under present law the telephone tax billed to a customer in a given semimonthly period is considered to be collected during the second following semimonthly period. The tax is deposited within three banking days after the semimonthly period in which it is considered to be collected. Under this proposal the tax would be collected during the first week of the second following semi-monthly period and would be deposited within three banking days after the end of that week. This change would be effective for taxes considered collected for semimonthly periods beginning after December 31, 1990.

(5) *Extend abandoned mine reclamation fees.* The abandoned mine reclamation fees, which are scheduled to expire in August 1992, would be extended. Collections from the existing fees of 35 cents per ton for surface mined coal and 15 cents per ton for underground mined coal are allocated to states for reclamation grants. Extensive abandoned land problems are expected to exist after all the money from the collection of existing fees is expended.

(6) *Establish Commodity Futures Trading Commission (CFTC)* fees. Effective October 1, 1990, a futures market transactions fee of 11 cents per transaction would be established to cover the cost of CFTC expenses.

(7) *Change collection point of special taxes in connection with liquor occupations.* To increase compliance rates and revenues, the special occupation taxes currently levied on retailers would be eliminated and the existing taxes on wholesalers and manufacturers would be increased effective October 1, 1990.

(8) *Extend social security (OASDI) coverage to D.C. employees.* This proposal would extend OASDI coverage to all newly hired D.C. employees effective January 1, 1991. Most D.C. employees are currently covered.

(9) *Extend IRS user fees.* The existing fee on each request for a letter ruling, determination letter, opinion, or other similar ruling or determination filed after January 31, 1988 and before October 1, 1990 would be permanently extended.

(10) *Establish Federal Emergency Management Agency (FEMA) user fees.* Beginning October 1, 1990, 100 percent of FEMAs costs incurred as the Nuclear Regulatory Commission's agent in regulating the evacuation plans of nuclear power plants would be recovered through user fees.

(11) *Extend and expand railroad unemployment insurance (UI) reimbursable status.* To prevent public subsidies from being diverted to pay for the high unemployment cost of the private sector railroads, public commuter railroads were exempt from the full railroad unemployment tax rate in 1989 and will continue to be exempt in 1990. Instead, they are required to reimburse the Unemployment Insurance Trust Fund for the actual costs of their employees. Under this proposal the exemption provided to public commuter railroads would be extended beyond its current law expiration date and would be expanded to Amtrak beginning in 1991.

(12) *Modify Federal Reserve reimbursement.* A permanent, indefinite appropriation to reimburse Federal Reserve banks for their services as fiscal agents for the Bureau of Public Debt will be established. This would result in a corresponding increase in the deposit of earnings by the Federal Reserve System, which are classified as receipts.

(13) *Delay for 3 months the Federal employee pay raise.* The Federal employee pay raise is proposed to be delayed 3 months from October 31, 1990 to January 1, 1991.

(14) *Establish Corps of Engineers application fees for permits.* Revised regulations are being developed that would enable the Corps of Engineers to begin collecting fees on requests for permits necessary for development or other activities in navigable waterways and wetlands. These fees would be effective October 1, 1990.

(15) *Other.* Additional proposals include an increase in the HUD interstate land sales fee and modification of the EPA pesticide fee.

Effects of the Proposals on Revenues

Treasury's Office of Tax Analysis estimates that—

(1) increasing D.C. contributions to CSRS will raise less than $50 million in FY 1991 and $200–$450 million from FY 1990 through FY 1995;

(2) increasing *ad valorem* fees on shippers will raise $300 million in FY 1991 and $1.7 billion from FY 1990 through FY 1995;

(3) increasing and expanding SEC fees will raise $100 million in FY 1991 and $550 million from FY 1990 through FY 1995;

(4) modifying the collection period of the telephone excise tax will raise $100 million in FY 1991 and $100–$300 million from FY 1990 through FY 1995;

(5) extending the abandoned mine reclamation fees will raise no revenue in FY 1991 and $1 billion from FY 1990 through FY 1995;

(6) establishing a CFTC fee will raise less than $50 million in FY 1991 and $200–$450 million from FY 1990 through FY 1995;

(7) changing the collection point for liquor occupation taxes will raise less than $50 million per year from FY 1990 through FY 1995;

(8) extending OASDI coverage to DC employees will raise $2 million in FY 1991 and $53 million from FY 1990 through FY 1995;

(9) extending IRS user fees on private letter rulings will raise $60 million in 1991 and $500 million from FY 1990 through FY 1995;

(10) establishing FEMA fees will raise less than $50 million per year from FY 1990 through FY 1995;

(11) extending and expanding railroad UI reimbursable status will lose less than $50 million in FY 1991, 1992, 1994 and FY 1995 and zero revenues in FY 1993;

(12) modifying the Federal Reserve reimbursement will raise $100 in FY 1991 and $500 million from FY 1990 through FY 1995;

(13) delaying the Federal pay raise will lose less than $50 billion in FY 1991 and (at most) $450 million from FY 1990 through FY 1995;

(14) establishing Corps of Engineers fees will raise less than $50 million per year from FY 1990 through FY 1995; and

(15) additional miscellaneous proposals included in the budget will lose, collectively, $100 million in FY 1991 and (at most) $450 million from FY 1991 through FY 1995.

The Joint Committee on Taxation has not estimated the revenue effects of these proposals. The Congressional Budget Office is expected to release its estimate of the proposals on March 7.

INTERNAL REVENUE SERVICE (IRS) ITEMS

In addition to the above revenue proposals, the Administration has proposed to improve budget receipts through management reforms and increased funding for enforcement and collection. The Office of Tax Analysis estimates that, taken together, the new resources and management reforms would lead to revenue increases of $3 billion in FY 1991 and $9.3 billion from FY 1991 through FY 1995. The Congressional Budget Office is not expected to estimate the revenue effects of this proposal.

IRS Management Reforms

The IRS currently allocates substantial resources to direct enforcement of the tax laws. IRS has identified key milestones for implementing certain management reforms and is establishing tracking systems to compare performance indicators to baseline levels of activity. In most cases, these management reforms would accelerate the receipt of taxes, penalties and interest. They include the following:

The inventory of large dollar cases in the appeals process has grown over the last few years. IRS will use a more targeted, revenue-maximizing approach in its case selection criteria.

Closure of an additional 30-50 large dollar cases in 1991 will result in an acceleration of $1 billion in receipts that generally would not be available for several years.

A transfer of 145 staff years from examination will allow continuation of baseline appeals work so that reallocation to high-yield activities can occur.

Examination FY 1991 Tax Shelter Initiative. Resources would be reallocated to accelerate the examination process for tax shelter cases with attendant expedited closure of such cases. As a result, an additional 58,000 cases will be closed in 1991. This will be accomplished by streamlining procedures and identifying tax shelter promotions (which involve multiple taxpayers) rather than working on a case by case basis. The overall impact involves a 2 year window of opportunity, and the FY 1991 estimated revenue will be $349 million.

CEP Settlement Authority. Examinations in the Coordinated Examination Program enter the administrative appeals process on unagreed issues at the close of the examination. This initiative would delegate appeals settlement authority to the CEP examiners on the basis of historical appeals settlement precedents. The result would be an acceleration of receipts as disagreement over assessments decreases from 90 percent to 60 percent. Appeals staff will work more closely with examination staff and technical decisions from the national office will be provided more expeditiously so that potential appeals issues can be resolved sooner. The FY 1991 effect is estimated to be $546.7 million.

Excise Tax Initiative. An additional 150 staff years of existing revenue agent staffing is to be redirected from lower yielding areas to examination of excise tax returns. The FY 1991 revenue effect is estimated to be $2.3 million.

Employee Plans/Exempt Organizations. This initiative focuses on the actuarial examinations of small retirement plans. Resources will be shifted from other examination and determination activities to this program, increasing the number of examinations in this area from the previously planned 700 to 18,000. A recent court decision has enhanced IRS's ability to conduct employee plan examinations on single issues of questionable actuarial assumptions. IRS will pursue closing a large number of cases by proposing settlement conditions and soliciting amended returns from plans which use such questionable assumptions to inflate plan contributions, thereby sheltering income from taxes. Of the 18,000 planned examinations, 5,400 are already in progress. The revenue effect starts in FY 1990 with additional collections of $64 million. There will be additional collections of $602 million in FY 1991.

Increase in IRS FY 1991 Enforcement Funding

The IRS currently allocates substantial resources to direct enforcement of the tax laws. Direct enforcement encompasses activities designed to encourage accurate reporting of taxable income and to assess or collect taxes, penalties, and interest which are owed but not paid. In allocating resources to these activities, the IRS does not simply seek to collect the maximum amount of taxes; rather, the objective is to encourage and enhance voluntary compliance (i.e., indirect revenue effects are considered).

The IRS has identified a number of enforcement areas in which specific problems exist that could be resolved by the application of additional resources. The specific programs, new budget authority and estimated FY 1991 receipts are as follows:

Examination District Office Initiative. An additional 1,049 staff years (and 127 support staff years) are to be applied to excise tax and estate and gift tax audits. Total budget authority for FY 1991 is $77.1 million, and the effect on collections in that year is a reduction of $18.2 million, due to initial opportunity costs.

Examination Service Center. This initiative will expand Service Center examination programs by applying an additional 640 staff years, with an FY 1991 budget authority of $27.5 million, to a variety of correspondence audits: Schedule A deductions, dependents, duplicated expenses, and deductions in excess of statutory limits. Collections in FY 1991 are estimated to increase by $143.6 million.

Examination Contract Training. Current training programs utilize experienced revenue agents as instructors. This initiative will reduce the opportunity costs of training by substituting contract instructors for a substantial portion of recruit classroom training. The FY 1991 budget authority is $7.5 million, and the estimated revenue impact for that year is $13.8 million.

Examination Claims Auditing. This initiative would apply 100 revenue agent staff years (and 46 support staff years), with a budget authority of $7.9 million in FY 1991, to increase examinations of claims for refunds of taxes. There is no estimated revenue impact for FY 1991.

Collection of Accounts Receivable. This initiative will apply an additional 1,050 revenue officer and support staff years, with total FY 1991 budget authority of $55.5 million, to the accounts receivable inventory. In FY 1991, increased collections of past due taxes, penalties and interest will amount to $150.2 million.

Returns Processing, Document Matching. This initiative would expand matching of noncustodial agreements by applying the equivalent of 366 staff years, with budget authority of $12.3 million, to this activity. The estimated increase in collections for FY 1991 is $172.6 million.

Returns Processing, Dependent SSN Matching. This initiative will expand matching of dependent social security numbers by application of the equivalent of 84 staff years, with a budget authority of $2.9 million. The estimated increase in collections for FY 1991 is $57.5 million.

Returns Processing, Mortgage Interest Credit. This initiative will expand matching of the mortgage interest credit by application of the equivalent of 14 additional staff years, with an FY 1991 budget authority of $0.5 million. Increased collections in FY 1991 are estimated to be $17.5 million.

CONCLUSION

The most important aspect of the FY 1991 budget is the emphasis placed on long-term national goals. Economic events have demonstrated the relationship between saving and investment and the problems created by our disappointing national saving rate. The package of incentives contained in the budget, particularly the proposed capital gains tax rate reduction for individuals, the Family Savings Accounts proposal and the proposed penalty-free IRA withdrawal for first-time home buyers, are designed to improve the national saving rate without increasing tax burdens on the American people.

The Bush Administration is prepared to work with Congress toward the enactment of these proposals. Let me emphasize as well Treasury's willingness to provide whatever assistance we can as the Committee examines the Administration's proposals and the tax and economic policy issues they raise.

Attachment.

Table 1
SURVEY OF CAPITAL GAINS REALIZATIONS ELASTICITIES

Studies	Data Type	Capital Gains Type	Realization Elasticity /1
Gillingham, Greenlees, and Zieschang (1989)	Pooled Cross-Section Time Series, 1977-85	All Capital Assets	3.80
Feldstein, Slemrod, and Yitzhaki (1980)	Cross-Section, High-Income Sample, 1973	Corporate Stocks	3.75
U.S. Treasury (1985)	Panel Data, 1971 to 1975	All Capital Assets Corporate Stocks	1.68 2.07
Auten, Burman, and Randolph (1989)	Panel Data, High-Income Sample, 1979 to 1983	All Capital Assets	1.65
Lindsey (1987)	Pooled Cross-Section and Time Series, 1965-1982	All Capital Assets	1.37
Jones (1989)	Time-Series 1948-1987	All Capital Assets	1.18
Darby, Gillingham, and Greenlees (1988)	Time Series, 1954 to 1985, All Taxpayers	All Capital Assets	1.07
Auten and Clotfelter (1982)	Panel Data, Middle-Income Sample, 1967 to 1973	All Capital Assets	0.91
Congressional Budget Office (1988)	Time Series, 1954 to 1985	All Capital Assets	0.89
Office of Tax Analysis (1990) 2/			Short-run 1.2 Long-run 0.8
U.S. Treasury (1985)	Time Series, 1954-1985	All Capital Assets	-0.80
Joint Committee on Taxation (1989) 3/			Short-run 1.2 Long-run 0.7
Minarik (1981)	Cross-Section High-Income Sample, 1973	Corporate Stocks	0.62
Auerbach (1988)	Time Series, 1954 to 1986	All Capital Assets	0.57

Sources: Council of Economic Advisors and Auten, Burman and Randolph (1989).

1/ The elasticity is the midpoint of the reported long-run elasticities for those studies reporting a range of elasticities for different models. The elasticities are not directly comparable in many cases. For example, the elasticities are computed at varying tax rates in the studies. In some studies the elasticities are the result of dynamic behavioral simultations, while in others the elasticity is computed at the average tax rate. In some cases the elasticities are derived from equations reported in the studies at a 25.4% tax rate after tax reform. These factors account for some of the differences in elasticities. Elasticities evaluated at current law tax rates would be higher for many of these studies.

2/ Based on an average tax rate of 20 percent, after portfolio effects.

3/ Based on announced values for last year's administration proposal, after portfolio effects. The JCT elasticities may be lower this year.

TABLE 2

REVENUE EFFECTS OF THE PRESIDENT'S CAPITAL GAINS PROPOSAL

Fiscal Year ($ Billions)

	Item 1/		1990	1991	1992	1993	1994	1995	1990-95
I.	Loss on Existing Gains Under Plan	2/	-2.1	-14.1	-14.4	-13.9	-14.7	-15.5	-74.7
II.	Effect of Taxpayer Behavior	2/	2.8	19.0	16.2	13.3	14.0	14.3	79.6
	a. Induced Realization Effect		2.8	19.1	16.7	14.2	15.5	16.3	84.6
	b. Conversion of Ordinary Income		0.0	-0.1	-0.5	-0.9	-1.5	-2.0	-5.0
III.	Depreciation Recapture		-0.0	-0.3	0.5	1.1	1.6	1.7	4.6
IV.	AMT Expansion		-0.0	-0.2	0.5	0.6	0.8	0.8	2.5
V.	Effective Date Effect		-0.2	0.4	0.0	0.0	0.0	0.0	0.2
VI.	Total Effect of Proposal		0.5	4.9	2.8	1.2	1.7	1.4	12.5

Department of the Treasury
Office of Tax Analysis

February 28, 1990

1/ Lines I through IV assume January 1, 1990 effective date. Line V shows the effect of an effective date of March 15, 1990.
All estimates ignore effects on economy. Details may not add to totals due to rounding.

2/ Estimates for a flat 30% exclusion are:

IA.	Loss on Existing Gains Under 30% Exclsion	-2.1	-14.3	-15.6	-16.6	-17.5	-18.4	-84.5
IIA.	Effect of Taxpayer Behavior Under 30% Exclsuion	2.8	19.3	18.4	17.0	16.6	17.0	91.1
	Induced Realization Effect	2.8	19.4	19.0	18.1	18.3	19.3	96.9
	Conversion of Ordinary Income	0.0	-0.1	-0.6	-1.1	-1.7	-2.3	-5.8
	Net Effect of Phase-in (I+II-IA-IIA)	0.0	-0.1	-1.0	-1.0	0.2	0.2	-1.7

TABLE 3

PRELIMINARY

- Table 1 -

ESTIMATED REVENUE EFFECTS OF THE ADMINISTRATION'S CAPITAL GAINS PROPOSAL

Fiscal Years 1990-1995

[Billions of Dollars]

	Item[1]	1990	1991	1992	1993	1994	1995	1990-95
I.	Static effect of the 30% exclusion[2]	-2.6	-17.7	-18.7	-19.9	-20.4	-20.9	-100.2
II.	Effect of induced realizations[3]	3.0	18.9	14.4	14.9	13.4	13.8	78.4
III.	Effect of full depreciation recapture	0.3	1.8	1.9	2.1	2.1	2.2	10.3
IV.	Effect of phase-in of the 3-year holding period	--	-0.3	-2.0	-0.9	0.4	1.6	-1.2
V.	Effect of treating excluded portion of gain as a preference item for AMT purposes	--	0.1	0.1	0.2	0.2	0.2	0.8
VI.	Effective date of the proposal[4]	0.1	0.6	--	--	--	--	0.7
	TOTAL, Revenue Effect of the Proposal	0.7	3.2	-4.3	-3.6	-4.3	-3.1	-11.4

Joint Committee on Taxation
February 13, 1990

NOTE: Details may not add to totals due to rounding.

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1 All estimates in this table are done incrementally; that is, assuming provisions described on preceeding lines of the table have been enacted.

2 This line reflects an estimate of the proposed exclusion assuming no change in taxpayer behavior.

3 This line reflects an estimate of the increase in budget receipts attributable to taxpayer decisions to realize more capital gains as a result of the lower tax rate.

4 Lines I-V, above, reflect a January 1, 1990, effective date; line VI represents an adjustment to these lines to reflect an assumed effective date of March 15, 1990.

Table 4

Total Capital Gains Realized
Under Current Law and an Across the Board rate Cut 1/
($ Billions)

Tax Year		Realizations Under Current Law	Realizations Under Rate Cut 1/	Change in Realizations Under Rate Cut 1/
1978		51	--	--
1979		73	--	--
1980		74	--	--
1981		81	--	--
1982		90	--	--
1983		123	--	--
1984		140	--	--
1985		171	--	--
1986		326	--	--
1987	P	144	--	--
1988	P	165	--	--
1989	E	185	--	--
1990	E	214	288	74
1991	E	236	308	72
1992	E	256	315	59
1993	E	270	338	68
1994	E	286	358	72
1995	E	300	373	73

Department of the Treasury February 28, 1990
Office of Tax Analysis

1/ Estimates are for the full plan and assume an effective date of 1/1/90.

'P', Data are preliminary.
'E', Estimate.

PREPARED STATEMENT OF JANICE M. GRUENDEL

Good Morning, Mr. Chairman and members of the committee. I am Janice M. Gruendel, deputy commissioner of the Connecticut Department of Children and Youth Services and a member of the American Public Welfare Association's National Council of State Human Service Administrators. I appreciate the opportunity to testify before you and to respond to the President's FY 91 budget proposals for at-risk children and their families.

In my testimony today, I hope to demonstrate to you that the Health and Human Services' budget request falls short of the necessary funding levels required to support comprehensive child and family social services to meet the crises in the child welfare system. Second, I will show how the administration's proposal to impose a cap on Title IV-E foster care is unwarranted and detrimental to children under our care. And finally, I would like to recommend that this Committee can help reestablish a strong Federal commitment to children by establishing adequate budget authority to support child welfare services aimed at strengthening families and improving the lives of vulnerable children.

I. FINANCING COMPREHENSIVE CHILDREN'S SERVICES

A. The Child Welfare Population Today

The nation's child welfare system is in crisis: the number of children and families we are called on to serve is increasing at an alarming speed. The rate of reported child abuse in 1987 was more than three times what it was in 1970; it has increased every year for the last 20 years without exception. In 1989, child protective services nationally received 2.2 million reports of child abuse and neglect.

The number of children placed in substitute care in the last three years has increased significantly. According to data collected by APWA's Voluntary Cooperative Information System (VCIS) funded by HHS, the number of children in substitute care increased by almost 30 percent between 1986 and 1989. At the end of 1989, there were 80,000 more children in care. The total number of children living outside their homes in substitute care increased from 280,000 to 360,000 in those three years. This increase reversed the downward trend of the substitute care population in the early 1980s.

Major new and serious social problems emerged in the 1980s, placing new burdens on our child and family social services. According to a recent study by the Center for the Study of Social Policy, the number of children living in poverty nationally increased 31 percent between 1979 and 1987. The dramatic increase in child poverty rates, drug addiction, homelessness, AIDS, as well as the growing numbers of deinstitutionalized or not-institutionalized young developmentally disabled and mentally ill persons, some of whom are also becoming parents now, puts child welfare agencies on the front line seeking to serve today's most troubled children and families.

The children coming into our system today are significantly different from the children we saw even 5 years ago. They are children who have been frequently and severely abused, have difficult health problems, or are developmentally disabled. We see a growing number of seriously handicapped infants coming into the child welfare system at one end of the spectrum, and a preponderance of emotionally disabled teenagers at the other end.

Workers in state child protective and welfare systems are literally under siege, especially in large urban centers. Let me give you a few examples:

• In *Philadelphia,* total reports of abuse and neglect doubled between 1982 and 1986. Between 1987 and 1989 alone this number increased by 31.6 percent. City officials project that the number of reports will double again between 1988 and 1994. They estimate that serious substance abuse is a factor in 60 to 80 percent of their abuse and neglect reports.

The City of Philadelphia's Department of Human Services provides services to 27,000 children each year. Of these children, 5,600 are in substitute care. If current trends continue the Department estimates that by 1994 there will be 9,200 children in dependent placements—an increase of 165 percent.

• In *California,* the child substitute care population has increased from 47,327 children in FY 86 to 66,763 children in FY 89—an increase of almost 20,000 children or 41.1 percent in three years. Between 1987 and 1988 the number of children in care increased by 20.6 percent alone.

California officials estimate that the number of cases of abuse and neglect reported with parental substance abuse rose from 66,841 to 122,153—an increase of 55,312 children or 82.8 percent.

• In *New York*, the number of allegations of child abuse and neglect involving drug withdrawal among newborns increased 210 percent from 1,569 cases in 1986 to 4,878 in 1988, just two years later.

The substitute care population in New York rose by 18,242 children or 66.3 percent in just two years from an overall population of 27,504 in 1986 to 45,746 in 1988. By 1989, the substitute care population increased another 21 percent to a total of 55,359 children.

Over two-thirds of the state's substitute care population resides in New York City. The proportion of children in substitute care living in New York City increased significantly from 61.1 percent in 1986 to 77 percent in 1989.

• In *Illinois*, the substitute care population increased by one-third between FY 86 and FY 89. In FY 86 Illinois provided substitute care to 14,427 children; by FY 89, the number of children in care had reached 19,296.

Despite the severity and visibility of this crisis, the Federal government has failed to respond adequately to the dramatic changes and the needs of the troubled children and families we serve.

B. Federal Funding Sources

In addition to significant state and local resources, states today use a variety of Federal funding streams to provide protection and serve children and their families, including the Social Services Block Grant/Title XX (SSBG/Title XX), Title IV-E Foster Care and Adoption Assistance, Title IV-B Child Welfare Services, and a variety of discretionary child abuse grants. Despite the phenomenal increase in child abuse reports, and the steadily rising number of children being placed in substitute care, funding has actually declined in some of these programs and has not kept pace with the need in others.

1. Title XX

According to the House Ways and Means Committee, Title XX funding declined in real terms, after adjusting for inflation, by almost $2.4 billion between 1978 and 1988, a reduction of 46 percent. If you adjust for population growth, the funding levels actually fell during this period by 51 percent.

When it created a new Title XX Social Services Block Grant in 1980 as part of P.L. 96-272, Congress intended funding levels for Title XX to increase. The law allowed the ceiling for Title XX to increase from $2.9 billion to $3 billion in FY 82 and $100 million a year until it reached $3.3 billion in FY 1985. But deep cuts were made in the program when Congress passed the Omnibus Budget Reconciliation Act of 1981 and funding has stayed well below the goals of P.L. 96-272. Last year, Congress increased funding for Title XX by $100 million—the first increase since 1984. Total funding for Title XX, however, was cut by $38 million in FY 90 because of the Gramm-Rudman-Hollings sequestration.

Data from 31 states submitting information to APWA's Voluntary Cooperative Information System for FY 86 indicate that well over a fourth of Federal and state SSBG/Title XX funds are used directly for child welfare related services: 9.8 percent of Title XX funding went for child protective services, 14 percent for substitute care and placement services for children and 2 percent for preventive services for children and their families.

Child welfare-related services are just one of many social services we provide with SSBG/Title XX money. The pressures to serve more elderly persons, disabled children and adults, and other needy citizens make it impossible for us to reallocate these scarce and shrinking dollars to child welfare without cutting services to these other populations.

The president's budget request for SSBG/Title XX does little to address the current need for services. The administration has requested only $2.8 billion to maintain funding at the FY 90 level which is not adequate to maintain current services let alone meet the ever-increasing demand for services. APWA favors an increase of $300 million in FY 91 and $200 million in FY 92 to restore funding to the levels authorized in FY 80.

2. The National Center on Child Abuse and Neglect

Federal funding for the National Center on Child Abuse and Neglect (NCCAN)—the only Federal agency mandated solely to address child maltreatment—declined significantly between 1981 and 1989. The administration's FY 90 budget request for $25 million is 21 percent lower than what would be needed to fund the program at the FY 81 service levels. During this same period the number of cases of abuse and neglect doubled. Although Congress recognized the tremendous need for services in this area by increasing the authorization levels to $40 million in FY 85, $41.5 million in FY 86, $43.1 million in FY 87, and $48 million in FY 88, funding actually

declined by almost $1 million between FY 85 and FY 90. President Bush's proposal to provide funding at the FY 90 level would continue to underfund these vital programs.

APWA supports full funding for the child abuse and prevention programs at the current authorized level of $48 million.

3. Emergency Child Protection Services

As part of a package of legislation to combat drug abuse last year Congress authorized a new $40 million program of grants to assist child protective services in dealing with the abused and neglected children of drug addicts. Unfortunately, an appropriation was not made to fund the program. Substance abuse has become a dominant factor in child abuse cases; this money is urgently needed by state child protective services coping with the effect of substance abuse.

The President's budget does not include a request to fund this critical program. APWA supports full funding of $40 million.

4. Title IV-B Child Welfare Services

Last year Congress raised the authorization level for Title IV-B from $266 million—where it had been since 1977—to $325 million. IV-A funding is used by states for direct services and purchase of services for more than 60 percent of the children in substitute care. In FY 90, Congress appropriated $252.6 million.

The president has requested an increase of $47 million to fund Title IV-A at $300 million. We support the increase. Having said that, Mr. Chairman, I would note that we strongly oppose the manner through which HHS would fund this increase. The budget proposal imposes a 10 percent cap on Title IV-E administrative expenditures, cutting $161 million from this program, and transferring $47 million of this cut to the Title IV-B program. I will return to this 'robbing Peter to pay Paul" approach in a moment.

5. Title IV-E Foster Care and Adoption Assistance

Funding requests for Title IV-E foster care and adoption assistance programs during the past decade have been woefully inadequate. Although Congress enacted Title IV-E as an entitlement program, legislative language in the appropriations' bill requires that annual appropriations be made to fund the program. HHS has consistently underestimated the costs of the program in its budget request to Congress. This budgetary practice has resulted in huge shortfalls to states who have had to carry the cost of the Federal share of the program. At one point in 1989, states were owed as much as $800 million for undisputed, prior year foster care claims.

The administration has requested $544 million in FY 91 to pay prior year foster care claims. We strongly support this request. We also are encouraged that the administration has sought to improve its budgetary practices to provide Congress with more realistic estimates on the cost of the program. We take issue, however, with the Administration's argument that they are increasing funding to the Title IV-E program by $1 billion over current services for FY 91. Over one half of this proposed increase is money already owed to states for unpaid and undisputed prior year claims.

The remainder of the funding request does represent an increase, but it is misleading to say that the budget request will result in $450 million more for foster care in FY 91 than in FY 90. The administration's baseline for FY 90 is not realistic and should not be used as a basis to compare funding for FY 91. By the Administration's own estimates, the baseline for FY 90 short-changes the states by approximately 277 million which will have to be supplemented through payments of prior year claims. By combining the Administration's FY 90 baseline with the back claims it expects to incur, the increase in funding over current services is closer to $239 million.

II. CAPPING THE TITLE IV-E FOSTER CARE PROGRAM

Mr. Chairman, I'd like to begin my discussion of the proposed cap to the Title IV-E program by thanking you for your efforts last session to block the Appropriations Committee's proposal to cap IV-E administrative expenditures. Without your intervention and the fine work of your staff, I'm afraid we would have lost the battle to protect the integrity of the Foster Care program and our ability to adequately serve children. Unfortunately, we haven't yet won the war.

The administration has proposed capping Title IV-E administrative costs beginning in FY 91. In the first year, the administration expects "savings" for the Federal Government of $161 million in budget authority ($121 million in outlays). What

this means is that these costs will be transferred to the states. By FY 95, the administration anticipates that states will be paying over $800 million more to fund the administrative activities associated with the foster care and adoption assistance programs than in FY 91.

The administration has long been concerned about the rising administrative costs in the Title IV-E program and has tried unsuccessfully to cap these expenditures over the last 10 years. The administration makes two arguments to support its proposal: first that the states are "gaining" the system to increase their IV-E reimbursement; and second, that this increased spending has not resulted in an "equal expansion in the quality or quantity of services to children." The administration claims that if a cap is not imposed, administrative costs will surpass maintenance costs.

This is a critical issue for the states, Mr. Chairman, and I would like to take a few minutes to set the record straight. First, HHS has never provided evidence to Congress that shows the states are claiming Federal reimbursement for anything other than legitimate costs. The public record is clear on this. The Office of the Inspector General for HHS issued a report in 1987, "Foster Care Administrative Costs," that disputes the department's charge that the states might have claimed illegal or inappropriate reimbursement. HHS Inspector General Richard P. Kusserow noted that the large increases in administrative costs since the mid-80s were due to the time it took for some states to gear up a new program and that in the early years there was significant underreporting of administrative costs. Many states had an artificially low base initially due both to their inability to claim all appropriate costs and the absence of required program components.

Kusserow also pointed out that what are called administrative costs in Title IV-E are unique and cannot be compared with administrative expenses in other programs such as AFDC, food stamps, or Medicaid. "Title IV-E foster care administrative expenses pay for service and program costs that would not be covered in other entitlement programs," he wrote. They cover a "wide variety of programs and services that would not be viewed as administrative costs under AFDC, Medicaid, or food stamps," but that the states are nonetheless required to provide.

The Inspector General included the following as legitimate "administrative" activities in foster care:

- referral to services;
- preparation for and participation in judicial determinations;
- placement in foster care;
- case reviews;
- case management and supervision;
- recruitment and licensing of foster homes and institutions; and
- rate setting.

Second, Mr. Chairman, the administration's claim that the states have not improved or expanded services to children and their families is simply not true. The vast majority of states have passed the Section 427 Compliance Reviews which demonstrate that states have totally revamped their child welfare systems to meet the requirements of P.L. 96-272. Although the number of children in substitute care has increased in recent years because of a variety of social and economic problems, the number of children in care actually had declined and remained steady for many years. Moreover, the length of time children remain in care has decreased significantly and that was a key goal of P.L. 96-272. And finally, the states have had to serve many more deeply troubled children in the last several years and have expanded services with an increasing level of state and local funding. The Administration has no instrument to measure the quality or quantity of services provided and has not published any document detailing their claim in this area.

Third, the Administration continues to perpetuate the misconception that administrative costs pay for "overhead costs." A significant proportion of administrative expenditures pay for the costs of carrying out the law and providing increased protections designed to keep children out of foster care when possible. These protections fall into the categories outlined by the Inspector General that meet the appropriate criteria for reimbursement under the IV-E program. States must provide the following protections or face fiscal sanctions:

- an inventory of all children in foster care for six months under the responsibility of the state;
- the implementation and operation of a statewide information system;
- a case review system for each child in foster care under the supervision of the state;

• a service program to help children return to their families or be placed for adoption or legal guardianship;
• and a preplacement preventive service program designed to help children remain with their families.

In addition, states must submit case record data for Federal review. States are sanctioned and suffer significant financial penalties if they are unable to meet the following protections:

1. States must develop a case plan for each child in foster care. In addition, they must meet nine other requirements, including establishing that the child is in the least restrictive setting, that there is a description of services offered; that the appropriateness of the placement is discussed.
2. States must provide periodic case reviews for every child in foster care no less than once every six months after the date of placement. The review must be timely and must meet six additional requirements that are designed to assure that foster children have been appropriately placed; that the state is complying with the case plan; and that progress has been made toward mitigating the need for placement.
3. States must also meet certain procedural safeguards, including respect for parental rights pertaining to the removal of a child from the home of the parents.

A cap on administrative expenditures will hurt children. There is no way around that. It will seriously undermine the ability of states to carry out the mandates of P.L. 96-272 and provide important protections to children who enter the state's child welfare system. Capping the program at a time when the number of children entering the system is increasing significantly will make it impossible for states to provide adequate protections or services. If administrative dollars are cut, states will be forced to shift scarce state dollars to pay for these essential services (administrative activities) and the overall result will be a reduction in services.

Capping the Title IV-E program will not penalize states that have already established sophisticated cost allocation methodologies to capture what is owed them. It will hurt those states, however, that have not yet begun to seek reimbursement for legitimate costs under this program. In the end, a cap would create a very unequal distribution of Federal resources, with some states reimbursed more fully for certain appropriate activities and others not.

Capping the Title IV-E program now, in the midst of serious problems such as increased substance abuse and child poverty rates which are having a significant impact on the child welfare system, is simply irresponsible.

We believe it is time for the Administration to stop perpetuating the idea that states are misusing administrative funding under the IV-E foster care program. It is also time that the Administration stop perpetuating the erroneous assumption that "administrative costs" in this program means overhead. Congress intended states to use Federal dollars matched dollar for dollar with state dollars to pay for services to ensure protections for children under their care. This we have done.

We urge the Committee to fight the $161 million cut requested by the Administration and to seek full funding for the Title IV-E program as it currently exists.

Thank you for this opportunity to testify. I will be happy to answer questions.

RESPONES TO WRITTEN QUESTIONS SUBMITTED BY THE COMMITTEE

Ms. Gruendel, I am troubled by the statistics you cite in your testimony (pp. 2 & 3), showing really extraordinary increases in foster care caseloads. The fact that New York's foster care population grew by 66 percent in 2 years, and other states have also experienced major increases, would seem to indicate that something very serious is happening to families and children in this country. Do you see this growth in foster care as a temporary phenomenon? And what do you think accounts for it?

Question 1. Do you see this growth in foster care as a temporary phenomenon?

Answer. No. This growth in foster care populations is by all accounts likely to increase for the next several years. According to the report, "No Place to Call Home: Discarded Children in America," published by the Select Committee on Children, Youth and Families, U.S. House of Representatives in early 1990 state foster care populations are expected to increase considerably by 1995. One estimate (Chart 1 of the report) projects an increase in the foster care population from 340,000 in 1988 to 553,600 in 1995.

Question 2. What do you think accounts for it?

Answer. Experts cite a number of factors as fueling this increased rate of foster care placements. Among the factors contributing to this rise, according to "No Place to Call Home," include:

• A greater rise in children entering care as compared with children leaving care; and
• Evidence that children are now staying in care longer.

A number of social factors feed into the above cited conclusions:

• Increased reports of child abuse and neglect resulting in more determinations that removal of the child from the home and placement in foster care is necessary. A large number of states indicate that these children's parents have been abusing drugs, particularly crack cocaine.
• Parental lack of adequate housing and/or homelessness are frequently cited as reasons why children in foster care cannot be returned to their families when reunification services have achieved positive results.
• Increased numbers of children in placement whose problems are such that they cannot be satisfactorily returned to their families.
• Instability of family functioning is also a reason cited as to why children in foster care cannot be returned to their families. Until alternative permanent placement arrangements—such as adoption—are completed, these children must remain in out-of-home care placements.

Prepared Statement of Senator John Heinz

Mr. Chairman, I am delighted that we are holding this hearing today to review the President's budget and the expiring tax provisions.

Earlier this year, Senators Moynihan, Danforth, Durenburger, Symms, Boren, and I introduced S. 2025, which combines all 12 of the expiring tax provisions into one bill, and makes them all permanent. The administrations budget proposes to make 3 of the provisions permanent—R&D, R&D allocation rules, and health insurance for the self employed—and it expends low income housing credit for one year.

The administration has never supported all of the extenders, and I doubt if they ever will. It is time that the administration realized that Congress supports all of the extenders, and help us to find a way to make them all permanent.

We have repeatedly extended these items. Some of the provisions have been in the code for over a decade, and yet we only extend them for a year or two at a time. We all know the arguments for making them permanent. It is impossible for the business community to rely upon these provisions when they have no idea if we are going to extend them again, or modify them one more time.

The provisions that the administration supports will cost $15 billion over 5 years. If we make all of the provisions permanent it will cost $22 billion over 5 years. I realize that this will not be easy—but if the administration is serious about making R&D and R&D allocation rules permanent, then they are going to have to work with us to make all the provisions permanent.

We have to work together if we are going to succeed.

Prepared Statement of Jeremy M. Jones

Mr. Chairman and members of the committee. I am pleased to be here today to review the impact the administration's proposed FY 1991 Medicare budget would have on the Home Medical Equipment (HME) Industry.

I. HIDA

The Health Industry Distributors Association (HIDA), created in 1902, is the industry's leading alliance of medical products distribution firms. HIDA represents more than 700 wholesalers and retailers serving the nation's hospitals, nursing homes, physicians, clinics, home care patients and other users of medical supplies and equipment. HIDA member companies play a key role in the delivery of quality health care to all Americans. HIDA is dedicated to working to build the best possible health care delivery system for our Nation.

II. NAMES

The National Association of Medical Equipment Suppliers (NAMES) is a nonprofit association composed of 2000 suppliers of home medical equipment. Pursuant to physician prescription, names members furnish a wide variety of equipment, supplies, and services for home use, including traditional items such as wheelchairs and hospital beds, and highly technical modalities and services such as specialized rehabilitation and nutritional equipment.

II. INTRODUCTION

The Home Medical Equipment Industry serves American citizens who need medical support in their home—if disabled, to lead productive lives or, if more severely ill, to live and to enjoy the home and its familiar surrounding rather than in a hospital or nursing home.

Taking care of these citizens in their home is far more desirable and believed to be more economical than hospital or nursing home care. Home care is cost effective and provides patients with a better quality of life. With Congress' decision to limit hospital care to those who need it most, more patients are being discharged to their homes, requiring more complete medical care.

Taking care of more patients at home obviously increases home care outlays—even while reducing institutional health care expenditures. As the number of patients cared for at home has grown, total outlays for home medical equipment have naturally increased. But, while total outlays have grown with the increase in beneficiaries served, Medicare expenditures for HME per beneficiary have declined due to annual reimbursement cuts.

Even while patient demands for health care and home services have grown, the Home Medical Equipment Industry has faced a series of *ad hoc* reductions in payments for equipment and services. the industry has adapted. We have increased managerial sophistication and efficiencies which have enabled us to continue serving home care patients. Now, however, the administration proposes to take $250 million out of reimbursement for this small segment of the health care industry—that is, *six percent* of cuts would come from *one percent* of the Medicare program or 11.6 percent of the administration's total $2.16 billion in part B savings proposals. (The CBO reestimated the President's budget proposals for FY 1991, reporting a 28-percent higher cost-saving value for proposed cuts in Medicare DME spending ($320 million) than the office of management and budget's $250 million estimate.)

We strongly object to this disproportionate reduction in HME expenditures, and urge the committee, should Medicare reductions be necessary, to keep any HME cuts proportional to overall cuts. After all, home care is an important part of the health care delivery system.

Already HME suppliers are no longer able to provide beneficiaries with requested services. Do not let this important Medicare benefit for home care further erode or beneficiaries will suffer further, and the persons providing those services will lose their jobs.

IV. THE ADMINISTRATION'S PROPOSALS FOR HME

A. National cap on fee schedules

The administration's FY 1991 budget proposal would repeal the current law (six-point plan) which implements regional fee schedules within allowed national limits in variation, and impose a national cap at the median of all local fee schedules. In addition, local fee schedules at or above the national cap would not receive a consumer price index (CPI) update.

Since 1984, HME has received only one consumer price index (CPI) update of 1.7% (on January 1, 1987). During the same seven years, we have had Gramm-Rudman reductions in 1986, 1987–1988, and 1989–1990. On top of these reductions, HME reimbursement has been further reduced by:

(1) 1985: A delay in reasonable charge update, July through September;
(2) 1986: A freeze on all reasonable charge increases, October 1985 through December 1986;
(3) 1987: The reasonable charge update was limited by inflation-index charges of 1.7%, January 1987 through May 1987;
(4) 1988: A reduction to lowest charge level (25th percentile) from the 75th percentile, May 1987 through December 1988; and
(5) 1989: 5 to 30 percent reductions in oxygen reimbursement, June 1989 through the present.
(6) 1990: A freeze on all reasonable charge increases through December 1990.

The overall impact of these various reductions means that:

(1) Medicare pays for sale items at 1983 prices with up to a 1.7% increase, less current Gramm Rudman reductions; and
(2) Medicare pays for equipment rental items at 1986 prices, less current Gramm Rudman reductions, with no CPI increases.

Because the HME industry is labor-intensive, it is essential that we receive a full CPI update in FY 1991. As I mentioned earlier, the HME industry has received an increase of only 1.7% (CPI) over the past 7 years.

The six-point plan fee schedule system for HME was passed as part of OBRA 1987. This major reform legislation, which completely overhauled the HME fee schedule rules, began implementation last June. The six-point plan will phase-in regional fee schedules for oxygen and most rental items beginning January, 1991. The regional fee schedule amounts will be further reduced through a process of limits based on allowed national variation, phased in during 1991 and 1992. Thus the White House proposal would abandon the phased implementation of a complex new law for an important Medicare benefit in mid stream. We strongly object to such a change, and continue to support the original plan congress enacted in 1987.

Regional, not national, fee schedules is the only system which makes sense for this industry. The HME business is inherently a local business. It is also primarily a service business, 24 hours a day, seven days a week, where labor costs are the single greatest expense.

The costs of providing HME services are driven by local factors because HME services are dictated by local medical practices and in some cases state regulation. This industry is, as is all of healthcare, labor intensive. Wages and benefits, based upon local variables, represent more than 60 percent of total expenses. That is substantially greater than the cost of our products. Other operational costs, such as office and warehouse space, trucks, gasoline, vehicle and equipment insurance, and heating vary enormously from one geographic region to another. The workmen's comp rate for driver/tech's is 1.59 per $100 in Indiana, 3.60/per $100 in Maine and 8.13 in California. The Congress, in enacting the six-point plan reform legislation in 1987, recognized that the costs of providing HME services vary by geographic area, and appropriately accounted for this fact. Last year the Congress recognized this as well when it rejected a national cap for HME.

Although the Medicare law refers to this important benefit as durable medical equipment, in fact, according to a 1987 study by Ernst and Whinney, "equipment acquisition is a relatively insignificant element of overall costs." The costs of providing HME are therefore not simply based upon the cost of the product, but upon the cost of providing the service in local communities.

B. MODIFY FEE SCHEDULE FOR HME RENTAL ITEMS

The administration would recalculate rental fee schedules based on average allowed charges rather than on submitted charges, and would reduce rental payments from 150 percent to 120 percent of the purchase price.

The current cap for rental items of 150 percent was adopted by Congress in OBRA 1987 only after careful consideration of all the facts and circumstances. After 21 months, suppliers may receive a small service and maintenance fee which continues semi-annually. Suppliers receive no further rental payments, and are not reimbursed for replacements if the item is lost, stolen or abused. Thus, the 150 percent provision recognized there are non-reimbursable costs suppliers will incur after the 15 month cap is reached.

Despite the Congress' recognition of future additional costs, the six-point plan has created many additional unforeseen liabilities—including major ongoing servicing responsibilities, declining returns on assets—the future impact of which are still unknown.

Demographics confirm there are more patients. Practical experience and industry research reveal that suppliers need more capital to maintain their operations to purchase new equipment and finance accounts receivable collection that averages 90 days. According to a definitive industry survey by Professor Ronald Stephenson of Indiana University, average profits and return on investment have declined by 50 percent in the last six years. Dr. Stephenson warns that current industry profits are insufficient to fund working capital requirements as beneficiaries' needs for services grow.

Because of decreased revenues, higher labor costs, and slower and unpredictable accounts receivables collections for Medicare services, the HME industry has a severe working capital problem. The shortage of working capital prevents the industry from investing quickly as demand requires. HME companies cannot gain access to needed capital from outside resources to purchase new products for the expanding beneficiary population due to low returns.

The administration's proposal is unsound health policy and would exacerbate the already poor financial health of the HME industry. Again, the administration's ideas are not new and were rejected by Congress in 1989. They deserve similar treatment this year.

C. REDUCE OXYGEN PAYMENTS BY 5 PERCENT

Although the six-point plan was designed to achieve a 5 percent reduction in oxygen expenditures, it actually produced between 5 and 30 percent reductions across the country. This is because the data used to calculate the reimbursement amounts for oxygen included low-use (PRN) patients who would not be eligible under today's more stringent oxygen coverage rules.

The dangerously low oxygen reimbursement amounts have already limited beneficiary access to these needed services in certain markets. For example, HME companies Glasrock and Lincare are closing Iowa branches, Homedco is losing money in Iowa and is no longer willing to provide certain ambulatory oxygen services. The Mayo Clinic has reported they can no longer discharge oxygen and ventilator patients into parts of Iowa because there are no longer suppliers in these locations to serve these patients.

D. OTHER ISSUES

The HME industry supports efforts to reduce inappropriate utilization, but reimbursement must be at levels sufficient to provide quality services to Medicare beneficiaries.

(1) The office of Inspector General and utilization control

The proper way for the IG to correct program abuses is to require HCFA to correctly and precisely define medical need; not to attack an entire industry.

HCFA also needs to place utilization accountability with the individuals who control utilization—the physicians. It is the doctor who determines whether a beneficiary needs a particular HME service, not the HME supplier. If a particular HME service is overutilized, the IG must analyze the medical necessity criteria on which physicians prescribe a service. HME suppliers provide products and services based on a doctor's orders. The industry does not create need.

(2) Mandatory assignment

Although Medicare administrative costs are very high, HME suppliers have a very high assignment rate. One reason it is not 100% is because a supplier can not currently take assignment and provide the beneficiary with an upgrade item that the patient can afford and wants. It can cost a supplier $25 to process one Medicare claim on behalf of a beneficiary. Consequently, HME suppliers do not provide assignment services on inexpensive products because they simply lose money on the transaction. Many beneficiaries do not file claims for purchased items.

Mandatory assignment would actually increase government expenditures because Medicare would be paying for items which are not now submitted to the program for payment.

(3) Regional HME carriers

Current law (the six-point plan) authorizes HCFA to establish regional or specialized carriers to process HME claims. Regional or specialized carriers would result in significant management and processing efficiencies.

V. THE ADMINISTRATION'S OTHER PART B PROPOSALS PROVIDE PRIOR AUTHORIZATION AUTHORITY TO CARRIERS

Currently, HCFA requires Medicare carriers to aggressively identify claims for HME that should not be paid or should be paid at a lower level. These activities, payment or program safeguards, may occur prior to the carrier decision to pay a claim (i.e. prepayment) or subsequent to the carrier decision to pay a claim (i.e. postpayment).

Requiring prior authorization on all HME payment claims would be unwieldy, impracticable, and only further delay payment on claims.

VI. CONCLUSION AND RECOMMENDATIONS

In conclusion, the HME industry strongly opposes the administration's $250 million in proposed HME cuts.

Suppliers of HME play a vital role in allowing many of our citizens, who might otherwise require hospital or nursing home care, to remain at home. These suppliers recognize the need to establish standards for payment under Medicare part B. The HME industry also recognizes that, due to growing budget deficits, reductions in expenditures in Medicare part B are unavoidable and is prepared to take its proportional share.

The HME industry urges, however, that any cuts in HME reimbursement be made in a manner least disruptive of patient care and consistent with the framework created by the HME reform law as passed in OBRA '87.

We as a nation ought to be encouraging home health care options, not ruling them out. This is true not just for fiscal reasons—it's less expensive to keep people at home than it is in an in-patient facility—but for quality of life reasons as well. Surely, if people can be properly cared for in the comfort of their familiar surroundings, we should be encouraging care at home.

We thank you for this opportunity to testify and look forward to working with you to find needed savings without disruption to quality patient care.

Enclosure.

HOMEDCO,
Fountain Valley, CA, April 11, 1990.

Ms. LAURA WILCOX, *Hearing Administrator,*
Senate Committee on Finance,
Washington, DC.

Dear Ms. Wilcox: I very much appreciate the opportunity to respond to Senator Bentsen's question from the March 22 hearing on the Administration's FY 1991 Medicare budget proposals.

Senator Bentsen asked whether the home medical equipment industry has shifted its position on receiving a full consumer price index (CPI) update.

Industry's position has not in any final sense "shifted." It has, however, necessarily evolved to take into account the results of last Fall's reconciliation process. OBRA '89 not only fully eliminated a PCI update for FY 1990 for all items of HME, but also imposed further Gramm-Rudman reductions throughout FY 1990. HME was subject to a 2.092 percent Gramm-Rudman reduction from October 1, 1989 through March 31, 1990; and a 1.4 percent reduction from April 1 through September 30, 1990. The magnitude of this action was unanticipated, and greatly exacerbated our experience of prior years. Perhaps you will recall that in the past seven years, the HME industry has received but one single CPI update (1.7 percent in 1987). During that same time, CPI costs have increased at least 20 percent.

It is the cumulative and unanticipated effect of years of virtually no CPI recognition that I was addressing in my testimony. In short, we simply cannot survive much longer without an appreciable recognition of a CPI update.

Further, the HME industry is actively developing specific targeted legislative proposals which preserve the integrity of the Six-Point Plan reform legislation and would support the need of the Committee to achieve specified savings from the HME industry. As soon as the Budget Committee has set the budget guidelines for Medicare savings, we will share these proposals with the Finance Committee.

In closing, I would also emphasize that we strongly support a "proportionality" approach to Medicare deficit reduction in which our industry absorbs no more budget cuts than its proportionate share of Medicare expenditures.

If we can be of any further assistance, please do not hesitate to contact me, (714-755-5600) Cara Bachenheimer, HIDA Director of Government Relations (703-549-4432), or Corrine Parver, NAMES Vice president, Government and Legal Affairs (703-836-6263).

Sincerely,

JEREMY M. JONES, *President and Chief Executive Officer.*

PREPARED STATEMENT OF PHILIP R. LEE

Mr. Chairman, I am pleased to be here on behalf of the Physician Payment Review Commission to discuss the President's proposals to slow the rate of increase in Medicare expenditures for physicians' services. The Commission's 1990 Annual Report to Congress will be submitted next week and I would be pleased to appear again before the Committee to discuss it.

In previous years, this Committee and others have asked the Commission for its advice on how to meet the targets for program savings set out in the Joint Concurrent Resolution on the Budget. Many of our suggestions have been incorporated into budget reconciliation acts. We are pleased to have been asked this year to participate in the process at a much earlier stage, when broad decisions on spending for Medicare have not yet been made. Our assessment of the Administration's proposals may be of use to you in your negotiations on the overall reduction in Medicare.

My statement has three parts. The first comments on the overall direction of the Administration's proposal, focusing particularly on its relationship to implementation of the major payment reform enacted last year. The second reviews the individual proposals for cuts in physician payment. The final section discusses the cost-estimating assumptions used by the Medicare Actuary and by the Congressional Budget Office (CBO) concerning responses by physicians to fee changes.

COMMENTS ON THE OVERALL PROPOSAL

The Administration has proposed reductions in Part B of Medicare totalling $2.2 billion, or 4.6 percent. These proposals would reduce a projected 11.2 percent increase in outlays to a 6.3 percent increase of $2.8 billion. However, various estimating assumptions, including a substantial increase in the volume of services in response to fee constraints, mean that a reduction in payment rates much larger than 4.6 percent is encompassed in these proposals.

These budget proposals come shortly after the passage of major reforms in physician payment under Medicare. Care must be taken to avoid meeting budget goals in ways that are inconsistent with the policy decisions underlying the reform or that call into question the Congress' steadfastness and its good faith in implementing a reform that was years in the making and was supported by both physicians and beneficiaries and by the Administration.

The Commission is particularly concerned that legislating sharp reductions in payment rates to take effect while we are in the process of implementing a major reform of physician payment could make the achievement of the objectives of the reform more difficult. Increasing the speed and magnitude of reductions in fees for services slated to be paid less under the Medicare Fee Schedule would exacerbate the disruption to physicians and the risks of limitations on access for beneficiaries. Moreover, substantial reductions in the Medicare Part B budget would limit the funds available for the crucial payment increases for evaluation and management services and for care delivered in rural areas.

Medicare payment rates for many physician services will change substantially over the next few years. The OBRA89 reductions in prevailing charges for overvalued procedures will take effect next month. Then, on January 1, 1992, the first phase of the Medicare Fee Schedule will be implemented. Between these two steps, the Commission estimates that 69 percent of the payment changes projected under the fully implemented fee schedule will have been made. For many overvalued procedures delivered in localities with high charges (for example, New York, Los Angeles, and Miami), the cumulative reductions in payment from this point to 1992 will total 23 percent.[1] For some physicians, limits on balance billing will reduce their revenue for these services by an even larger percentage. The Administration's proposals would increase these reductions substantially.

Unless other payers follow the lead of Medicare in restructuring their pattern of physician payment, the difference between Medicare payment rates and those of other payers might be substantial for some services in some communities. While initial indications suggest that many private payers and state Medicaid programs will follow Medicare's lead, it will take some time before they actually decide on and implement payment changes. By beginning implementation of the fee schedule in 1992 and stretching the transition out over a number of years, the Congress provided time for other payers to decide to follow Medicare's lead and to implement their changes before the Medicare changes were complete. This will minimize discrepancies in payment rates. If the transition were accelerated, as called for by a number of the proposals in the Administration's budget, this opportunity for limiting payment differences would be lost.

SPECIFIC BUDGET PROPOSALS

The Commission has discussed the specific proposals in the Administration's budget and is concerned that many of them are inconsistent with the payment reform that was enacted last year with the support of the Bush Administration. With payment reform following a schedule carefully worked out in the Congress last year, subsequent budget requirements are best met through broad-based constraints on payment. Some of the specific proposals either accelerate payment reductions to too large a degree or make changes that are at odds with the basic philosophy of

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[1] Take, for example, a service that is slated to decline by 45 percent in a locality under the fully implemented fee schedule. Its payment will be reduced by 15 percent under the overvalued procedure policy and an additional 8.25 percent (15 percent of 55 percent of the payment under 1989 policy).

payment reform—to determine payment on the basis of relative resource costs. Some of the proposals affecting narrow categories of services do have merit, however.

Update Only for Primary Care Services

The Administration has proposed to eliminate the annual update in the MEI for 1991 except for primary care services. The Commission strongly supports the exemption of primary care services, which it first suggested for OBRA87. A reduction in the MEI update for all other services is a way of meeting budget reduction targets that is consistent with the payment reform.

Reduce Payments for Certain Overvalued Procedures

The Administration proposes further reductions in prevailing charges for the services identified as "overvalued" in OBRA89. OBRA89 reduced payments by one-third of the amount by which the procedure was estimated to be overvalued in each locality up to a maximum of 15 percent. This proposal would reduce payment for these procedures by two-thirds of the remaining amount up to a maximum of 25 percent.

The Commission has concerns about these deeper cuts in the same procedures at this time. When the Commission developed the recommendation last year at the request of this Committee, it advised that payments be reduced by no more than one-third of the difference between current levels and the amount projected under the fee schedule. The judgment of one-third reflected the preliminary nature of the data that were used to estimate the fee schedule. These data come from the physician work estimates in the first phase of the study by William Hsiao and colleagues and the Commission's initial refinements to estimates of practice costs. These data will be augmented and refined further prior to the implementation of the Medicare Fee Schedule in 1992.

Because of limitations in the data, the Commission judged that it would not be prudent to reduce payments beyond one-third. Larger reductions risk overshooting the final fee schedule levels. This could pose risks to beneficiary access for those services and detract from the credibility of the physician payment reform. In addition, limiting the percentage reductions in payment for overvalued procedures mitigates inequities between those specialties studied in the first phase of the Hsiao study and those that were not.

Since that time, nothing has changed to give the Commission increased confidence in its estimates, nor is there data for estimates for additional specialties. The Hsiao team has not yet delivered results from the second phase of their study. Thus, at this point in time, the Commission does not have any better data to develop estimates of the fee schedule than it did last spring. The Commission would prefer that reductions for overvalued procedures be based on stronger estimates. This will require additional data. From our understanding of the progress of the second phase of the Hsiao study, it is our belief that Dr. Hsiao could soon deliver to HCFA the results for most of the specialties being studied. This would permit estimates of Medicare Fee Schedule amounts to be developed for additional services and revisions to be made for some of the estimates for services studied in the first phase. We urge the Congress and HCFA to press Dr. Hsiao for early delivery of results for most of the specialties studied in the second phase of his research rather than waiting until all of his studies have been completed, which could be as late as next year. Early delivery would also assist the Health Care Financing Administration and the Commission in their tasks to prepare for the timely implementation of the Medicare Fee Schedule.

Reduce Radiology and Anesthesia Fees

The Administration is proposing reductions in payments for radiology and anesthesia services.[2] For all localities in which the conversion factors for these existing fee schedules exceed the current estimate for the overall Medicare Fee Schedule, the Administration proposes to eliminate the difference, up to a maximum reduction of 25 percent.

The Commission supports reductions in payments for radiology and anesthesia, but is concerned that the proposed reduction is too large. While the Commission has not yet developed a precise estimate of the change in the overall conversion factors for these fee schedules, the Administration's working assumption that these services will be reduced by at least 10 percent under the Medicare Fee Schedule appears to

[2] The Administration's proposal did not include reductions for pathology services, which also appear to be overvalued.

be reasonable. We also support the Administration's incorporation of a geographic adjustment, so that reductions will vary by locality.

Reducing payment rates the full distance to the levels projected for the full fee schedule, up to a maximum of 25 percent, is too extreme. It goes far beyond the overvalued procedure policy, which moved payment only a fraction of the distance to the fee schedule and which affects a much smaller portion of the services provided by the physicians who perform them. Presumably, this proposal would reduce payment for virtually all Medicare services provided by radiologists and anesthesiologists.[3] [4]

Technical Components of Diagnostic and Radiology Tests

The Administration proposes to cap payments for the technical components of diagnostic and radiology tests at the national median. While this parallels the approach taken for clinical laboratory services, it is not consistent with the resource-based approach to the Medicare Fee Schedule. First, geographic differences in the costs of providing these services should be recognized in the payment system, but this proposal would not adjust for such differences before applying a cap. Second, large changes in payments for technical components should await the Commission's estimates of costs for these procedures, which are being developed over the next year with data from large medical practices.

Reduced Payments for Overvalued Localities

The Administration proposes to reduce payments for procedures in "overvalued" localities, that is, localities in which the prevailing charge after adjustment by the geographic practice cost index (GPCI) exceeds the national average. The reductions would not apply to services for which payment is expected to increase under the fee schedule and to services affected by the other budget proposals of the Administration. The maximum reduction would be 25 percent.

While the concept of reducing payment for services in overvalued localities has merit, the specifics of this proposal raise problems. First, the magnitude of the reduction seems too large to put into effect during so short a period of time. Physicians in some localities could experience reductions of up to 25 percent for many of their services. The magnitude far exceeds the speed of the transition to the Medicare Fee Schedule developed by the Congress.

Second, the lack of any estimates at this point on the final fee schedule amount for many of the services that would be affected by this proposal leads to a high risk of reducing payment for particular procedures too sharply. The proposal excludes both those services projected to increase under the fee schedule and overvalued procedures. Most of the services remaining are those not yet studied by Dr. Hsiao, those judged overvalued by less than 10 percent (some of which could turn out to be properly valued or even undervalued once additional data are available), and those for which the data were too questionable to be considered for the overvalued procedure list.

Reform Payments for Assistants at Surgery

The Administration proposes to subtract payments for assistants at surgery from the payment to the primary surgeon. The proposal is based on evidence of substantial geographic variation in the use of physicians as assistants at surgery and on the substantial use of primary care physicians in this capacity.

The Commission shares the Administration's assessment that the use of a physician as an assistant at surgery is often unnecessary, but advises against the adoption of this proposal for two reasons. First, there are certain surgical procedures that virtually always require a surgeon as an assistant. For these procedures, the proposal is equivalent to an additional 20 percent fee reduction to the primary surgeon, except for procedures performed in teaching hospitals, in which surgical residents routinely provide assistance. Second, the proposal could be interpreted as calling for "fee splitting," an arrangement that is strongly at odds with deeply-held professional principles.

The Commission plans to explore two alternatives to the Administration's proposal. First, lists of surgical procedures could be developed for which no payment would

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[3] It is important that policies to reduce payment for radiology, such as the one proposed by the Administration, are limited in their application to the professional components of services. Data from the Hsiao study, which are the basis for the adjustment of the conversion factors in the Radiology Fee Schedule, apply only to the professional services delivered by radiologists and other physicians, not to the technical services that are often combined with them in payment.

be made for assistants at surgery.[5] These could be developed by reference to data on incidence of use of assistants at various geographic locations. For each CPT code in which assistants are seldom used at a substantial number of nonteaching hospitals, Medicare would not pay for any assistants. The second alternative would have hospitals pay for assistants at surgery. The primary surgeon would negotiate with the hospital as to whether an M.D. assistant or an operating room nurse should be provided for an operation, either of which would be paid by the hospital. Medicare payments to hospitals under the Prospective Payment System would have to be increased slightly to cover these costs.

Reduce Surgical Global Fees

The Administration proposes to reduce surgical payments by 2 percent (or procedure-specific amounts where data are available). The rationale is that as lengths of stay have declined over time, the number of postoperative visits have declined and that global fees for surgery have not been adjusted to reflect this.

The Commission has two problems with this proposal. First, a much more accurate treatment of global payment for surgery will be implemented only one year later, when the fee schedule values are calibrated to reflect a uniform definition of the global service. Second, the Commission's calculations that were used by Congress in OBRA89 for overvalued procedure reductions incorporated 1989 estimates of resources incorporated in the global service. Applying the proposed reduction to these procedures would amount to double counting.

Lower Payment Rate for New Physicians

This proposal would extend previous policies to apply more stringent limits on payments to new physicians. The Commission has advised against this policy in the past and maintains that position. With Medicare slated to pay on a fee schedule basis instead of reasonable charges, the proposal has even less merit than in the past. The Commission sees little reason to pay each new physician less than others for four years.

Voluntary Hospital Physician Participation

The Administration has proposed that hospitals have the option to become "Medicare participating physician medical staff hospitals." Hospitals could sign an agreement under which they would guarantee that physicians would accept assignment for emergency services, radiology, anesthesiology, pathology, and consultations. Hospitals would be free to advertise their status.

The Commission has not yet discussed this proposal, but I suspect that it will react very favorably to it. The Commission has long had concerns about balance billing in situations where the beneficiary has no choice of physician. It also has applauded the participating physician program for increasing assignment. This proposal may contribute to increases in assignment where beneficiaries have no choice of physician.

ASSUMPTIONS BEHIND ESTIMATES OF SAVINGS

The Commission has been concerned for some time about one of the assumptions used by both the Medicare Actuary and the CBO in estimating savings from payment reductions. Both organizations assume that reductions in physicians' real (inflation-adjusted) fees will induce physicians to increase the volume of services provided to Medicare patients. They assume that induced increases in volume will offset 50 percent of the initial outlay reduction from decreases in fees. This means that in order to reduce outlays by 5 percent, fees must be cut by 10 percent. While the notion of a volume response to changes in fees does have a basis in the research literature, we suspect that the magnitude of the offset is too large.

Examination of recent Medicare data raises doubts about the magnitude of these offsets. Data from the most recent Trustees' Report shows that between 1984 and 1989, real Medicare fees for physicians' services declined by 24 percent.[6] But volume of services grew at about the same rate it has since the mid-1970s and, in fact, at a slower rate than in the early 1980s. While other factors, such as technological change undoubtedly played roles, it is instructive that during a period in which Medicare payments were cut sharply, the trend of volume increases did not change

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[4] The Commission has only recently begun to take up issues of payment to certified registered nurse anesthetists (CRNAs) and thus is not yet ready to comment on the Administration's proposal in this area.

[5] In previous legislation, the Congress prohibited payment for assistants in cataract surgery unless specifically approved in advance by the Peer Review Organization.

noticeably. The 12 percent volume offset that had been projected is not apparent in these data.

Other factors lead one to question whether the offset is too large. Medicare fee reductions to date have focused on major surgery. Given the risks of surgery and the role played by referring physicians, a strong volume response to reductions in fee levels seems questionable. Additionally, increased scrutiny of surgical procedures by Medicare could lead the magnitude of any response to be smaller than in the past.

CONCLUSIONS

While the need to reduce Federal spending continues, sharp reductions in Medicare payment for physicians' services at this point carry substantial risks. Large reductions that coincide with the implementation of payment reform would jeopardize some of what the Congress accomplished last year.

I hope that the Commission's analysis of the specific proposals from the Administration will help the Committee both in its assessment of overall budget reduction targets and its development of specific policy options once the target has been set. The Commission stands ready to assist with further analysis and development of specific options.

PREPARED STATEMENT OF J. LEONARD LICHTENFELD

I am J. Leonard Lichtenfeld, MD. As an internist in private practice in Baltimore, Maryland and President-elect of the Maryland Society of Internal Medicine, I have been directly involved with Medicare policies on both the national and state level. I am pleased to share with you the views of the American Society of Internal Medicine (ASIM) on proposed budget and policy initiatives relating to the Medicare program.

Let me begin by expressing ASIM's heartfelt thanks and commendations for what this committee has already accomplished. The physician payment reform package adopted by Congress in OBRA '89 would not have come about without the support, persistence and initiative of the members of the Finance Committee. We particularly appreciated the willingness of Chairman Bensten and Subcommittee Chairman Rockefeller to consider all views in developing a historic consensus for reform.

But this is not the time for you—or we—to be complacent with what has been accomplished. OBRA '89 represents a blueprint for reform. But the decisions that Congress makes now on proposed cuts in Medicare Part B will have a direct effect on whether or not the high expectations surrounding last year's physician payment reform package are, in fact, met. The Finance Committee also has a responsibility to oversee HCFA's implementation of the new fee schedule to assure tat Congress' intent to eliminate historical inequities in payment is preserved.

Let me elaborate on our specific concerns.

FY 1990 PROPOSED MEDICARE CUTS

If the administration has its way, the long-term benefits of physician payment reform will be sacrificed in order to attain immediate FY 1991 budget savings.

By calling for $2 billion in cuts in the Medicare Part B program, the budget threatens to deny patients the benefits—such as improved access to care in rural communities—intended by Congress when it enacted Medicare physician payment reform.

The budget borrows the language of reform while working to undermine it. The administration justifies many of its proposed cuts, such as the proposed reductions in overpriced procedures, under the guise of improving equity. But no one should be fooled. Instead of improving equity, further cuts will detract from the ability of the new Medicare fee schedule to correct inequities that now threaten access to primary care services, particularly in rural areas. Since 1991 is the base year for determining a budget neutral conversion factor for the new Medicare fee schedule, the proposed cuts would require that the conversion factor be set at a proportionately lower level in order to maintain budget neutrality. The Congressional Budget Office agrees that further cuts in overpriced procedures "would lower the base for setting new rates for all physicians." *This would reduce any gains in Medicare payments for undervalued services under the new RBRVS Medicare fee schedule.* (Source: CBO, *Reducing the Deficit: Spending and Revenue Options,* February 1990.) In that case, everyone loses.

Rural communities will be dismayed to find that the new fee schedule does not provide sufficient incentives to attract and maintain primary care physicians. Physicians who hoped that their primary care services would be paid more fairly will feel betrayed when they realize that more cuts—but few or no increases—are in store. It makes no sense for Congress to enact major reforms in physician payment—only to let those reforms be circumvented through the budget process.

Internists are also concerned that continued cuts in Medicare will inevitably compromise availability and quality of care. Medicare was cut by $36 billion over fiscal years 81-87, and by billions more over the past two years. So far, the medical profession's commitment to providing patients with the care that they require has insulated beneficiaries from the consequences of those cuts. But one only needs to look at the Medicaid program to conclude that when insufficient resources are devoted to medical care, patient care sooner or later will suffer.

There is growing evidence that low levels of reimbursement, coupled with the growing administrative burdens—or hassle factors—associated with the Medicare program, may be beginning to harm access. A recent survey of internists in New York State found, for example, that internists feel increasingly pessimistic about the future of medical practice. Thirty-six percent agreed with the statement that "If I were given the opportunity to retire in the next year, I would give it serious consideration." Eighty-four percent disagreed that "the future environment will probably improve and become more rewarding over the long-term." The authors of the study conclude that more and more senior physicians-the most productive, skilled members of the profession—are leaving private practice for administrative and salaried positions. Students and residents, they report, share the same negativism, with the result that fewer are selecting internal medicine. Most importantly, the authors argue that "If withdrawal from practice combines with the inability to attract medical students into the field, it is not difficult to construct a scenario in which physicians in practice will be difficult to find." (Source: Hershey, McAloon, and Bertram, "New Medical Practice Environment: Internists' View of the Future," *Archives of Internal Medicine*, August 1989.)

Their concern is supported by the difficulties internal medicine residency programs have experienced in recent years in attracting a sufficient number of residents, and by the growing anecdotal reports of practicing internists leaving practice, restricting the numbers of Medicare patients that they are willing to see, and discouraging younger physicians from entering primary care.

The RBRVS fee schedule offers the promise of reversing some of the pessimism that may be discouraging physicians from entering primary care. But if Congress agrees now to cuts that diminish the promised gains in reimbursement for primary care, internists will understandably feel betrayed. In that case, the scenario predicted above—that it soon may be difficult for patients to find physicians in practice, particularly if they are a Medicare beneficiaries—may be closer at hand than many of us would like to believe. If Congress errs on the side of cutting Medicare too deeply, with the result that an insufficient number of physicians enter primary care, it may take another 15 years to correct the problem. ASIM urges the Finance committee not to be taken in by the administration's rhetoric of reform. Substantial cuts this year in Part B will directly take away from the promised gains in 1992 for underpriced services. While we fully recognize the need to make appropriate reductions in fees for overpriced procedures once the RBRVS fee schedule is implemented, applying the RBRVS methodology prematurely to justify the administration's budget cuts—without applying it to increase fees now for underpriced services—is highly inappropriate.

We also urge the committee to heed the warnings about pending access problems if the Medicare program continues to be cut each year and if the regulatory burden on physicians continues to grow unabated. Beneficiaries have a right to expect that Congress and the medical profession will act now to maintain access to services, rather than waiting until the crisis is here.

ASIM is pleased that the ranking minority member of the Finance committee, Senator Bob Packwood, has introduced legislation, S. 2214, that begins to address the real concern about access to care in rural communities. His bill would allow the full increases in reimbursement expected by the RBRVS fee schedule to take place all at once on January 1, 1992, rather than being implemented in stages as mandated by OBRA '89. Although Congress is unlikely to reopen the timetable for implementation of the new RBRVS fee schedule, ASIM appreciates Senator Packwood's effort to highlight the urgency of the problem facing rural physicians. Short of moving up full implementation of the fee schedule, other measures—such as providing for a greater than MEl increase for primary care services in 1991—should be considered.

In addition to ASIM's strong opposition to the overall magnitude of Part B cuts proposed by the President, we are particularly concerned about the proposal to permanently extend limits on reimbursement to new physicians. In the past, limiting payments to new physicians to a percentage of prevailing charges was rationalized on the basis that they lacked their own customary charge profile, and that was unfair to established physicians to set the charges of new physicians at a level that was higher than many of their colleagues already in practice. Once the RBRVS fee schedule is implemented, however, there is no need to develop a methodology for establishing customary charges for new physicians. Fairness and administrative simplicity would argue for new physicians to receive the same level of reimbursement as any other physician for a service involving the same resource costs. We urge the committee to reject this proposal.

CALCULATION OF THE DOLLAR CONVERSION FACTOR

As the committee is aware, the new fee schedule is the product of the RBRVS and a dollar conversion factor. The manner in which the initial dollar conversion factor is calculated will therefore determine if the new system truly improves reimbursement for undervalued cognitive-or evaluation and management—services, or if it instead perpetuates and exacerbates existing inequities.

For years, many physicians have worried that even if Congress agreed to an RBRVS, it would ultimately be implemented by HCFA in a way that simply slashes physician fees across-the-board. If the dollar conversion factor is set too low, few (if any) evaluation and management services would see any real increase in reimbursement, while surgical and diagnostic procedures would be subject to severe reductions.

Clearly, that is not the intent of the Commission or Congress. But it may be the intent of the administration. Although OBRA '89 specifies that the conversion factor for 1992 must be established in a "budget neutral" manner, which would permit real increases in payment for underpaid services and locales, there is considerable discretion given to the Secretary of the Department of Health and Human services on how such a "budget neutral" conversion factor is to be calculated. The Secretary is permitted, for example, to consider "unexpected behavioral changes" in establishing the conversion factor.

The administration's October 1989 report to Congress, titled "Reports to Congress: Medicare Physician Payment," suggests that the administration intends to assume that volume will increase substantially under the RBRVS fee schedule, in order to justify a much lower dollar conversion factor than would otherwise be required to maintain budget neutrality. The administration argues that "Many analysts believe that a resource-based fee schedule could trigger a significant increase in volume, as physicians who face payment reductions under the fee schedule attempt to offset reductions by increasing billings. This, in turn, could lead to a major increase in Medicare expenditures. As a practical matter, some behavioral adjustment must be made when setting the fee schedule conversion factor."

Later, the report states that "It is the position of the Department that the 50 percent response (50% increase in volume) is the most likely (behavioral response to the new fee schedule)." Finally, the administration argues that "strong arguments can be made to support the view that there are relatively few undervalued services."

If the administration is permitted to assume a significant "behavioral offset" in establishing the initial dollar conversion factor, all or most of the gains for undervalued cognitive services would be lost. This would not only violate the intent of Congress in enacting the new law, but would also permanently strip the new system of any credibility with the physician community.

ASIM strongly urges the Finance Committee to oversee how the dollar conversion factor is developed by HHS to preserve Congress' intent that payments for undervalued services be substantially increased. The Committee should specifically reject the inclusion of any "behavioral offset" in establishing the initial conversion factor. "Unexpected changes in physician behavior" should be factored into the conversion factor only if there is hard evidence, based on actual trends in utilization following the initial phase-in of the RBRVS fee schedule, to justify such an offset. Medicare volume performance standards, as mandated by OBRA '89, provide a means for making such adjustments. The administration's apparent intent to assume "a priori" a substantial increase in volume should be recognized for what it is: a thinly-veiled attempt to use the new reform package simply as a budget-cutting tool, rather than as a means to improve equity, access and quality.

MEDICARE VOLUME PERFORMANCE STANDARDS

OBRA '89 requires the Secretary to propose separate volume performance standards for surgery and other services, and gives the Secretary broad discretion to propose separate standards for other categories of services and separate conversion factor updates by categories of services. The Secretary's recommendations for the FY 1991 MVPS must be submitted to Congress next month.

ASIM believes that ideally there should be one volume performance standard and one conversion factor for all physician services. If physicians who commonly provide' one category of services are allowed to negotiate a more favorable standard, and by doing so obtain a more favorable fee update for those services than for other categories of services, the relative values and equity established by the RBRVS will be undermined over time. If one category of services consistently receives relatively higher dollar conversion factors than other services, those services would once again be paid disproportionately better for the time, effort, skill and overhead involved than for services requiring comparable work. The same inequities and distortions that the RBRVS was designed to correct would return. It seems illogical to us to spend years of effort developing the RBRVS, only to immediately begin changing the relative relationships established by that scale based on a totally untested system of volume performance standards.

In addition, instead of working together as a profession to collectively identify ways to appropriately control the volume of all physician services, the incentive will be for the profession to fragment into separate camps whose primary interest is to negotiate the most preferential target—and fee update—for their respective services. Individual specialties will understandably try to narrowly define the services to be included in the standard that covers their most commonly performed services, so that high volume items are included in some other standard. If, for example, utilization of certain diagnostic procedures done by both internists and surgeons have increased at a rapid rate, surgeons will have every incentive to attempt to exclude such procedures from the surgery standard—while internists will have every incentive not to want such procedures included in the category of services affecting payments for visits and other services. Undesirable behavioral responses—such as doing more of services in another category in order to offset reductions in the utilization of services in the category that most affects your "specialty—are probable.

The result will be that instead of working together to solve the problem, each specialty will try to shift the problem—and blame—to someone else. At a time when it is critical that the profession stand together, we will instead have fragmentation and divisiveness.

ASIM believes that Congress should reject any recommendation for separate standards and fee updates by categories of services, and instead should enact a single FY 1991 volume standard encompassing all physician services.

DOWNCODING OF SERVICES

ASIM also strongly urges the Committee to address the problems being created by the widespread "downcoding" of evaluation and management services by Medicare carriers. Internists nationwide are finding that carriers routinely are downcoding intermediate, extended and comprehensive visits to lower levels of care. As a result, the already low levels of reimbursement for cognitive services are being further reduced.

We have no disagreement with targeting for intensified review physicians who are truly billing for a higher level of service than is appropriate. But services that are billed and coded correctly are also being denied. A recent report by the HHS Inspector General states that it is the opinion of the department that physicians should bill no higher than a "limited" visit as their usual or routine visit, regardless of their specialty or the complexity of their patient case mix. ("Problems With Coding of Physician Services: Medicare Part B," January 1989). Apparently, this determination was never communicated to physicians or carriers, except in the case of the Dallas regional office. Many carriers, in fact, advised internists to bill for their typical visits at an intermediate level. (The IG reports that half of the carriers in practice recognized codes other than limited or brief as the "most correct" for billing for "routine" visits). Now HHS appears to be intent on requiring carriers to downcode any bills for regular visits that are higher than a limited visit.

ASIM categorically rejects the conclusion that a "limited" visit is the appropriate code for the typical service rendered by an internist or internist-subspecialist. Since internists typically see older, sicker and frailer patients requiring relatively more time and effort, billing for a higher level of service is often merited. We also object to HHS making this determination without any consultation with ASIM or other

representative organizations. We further object to applying this determination to physicians who had been advised by their carriers to bill for a higher level of service, or had in practice been authorized to do so. It is patently unfair for the program to tell physicians to bill things one way, later change its mind—and then hold physicians' financially liable for doing what they were told to do in the first place! Had internists known years ago that only a limited visit would be recognized in the future, they would have increased their fees for this level of service to assure an appropriate charge for the work involved. But they did not know, could not have known. Now, with MAACs in effect, they are unable to raise their fees for the service. The result is to significantly lower reimbursement for the same evaluation and management services that the RBRVS fee schedule is designed to increase.

Mandating a fee schedule that pays more for each level of service does no good if the Medicare program can simply offset those increases by routinely downcoding those services to a lower level of care. Downcoding of services is one way that HHS can undo through implementation the intent of Congress in mandating the RBRVS fee schedule.

We believe that it is critical that Congress take action to prevent further arbitrary downcoding of services or collapsing of codes. Until the study of evaluation and management codes is completed, HHS should be prohibited from enforcing any directive to reimburse at no higher than a limited level for so-called "routine" visits. Further, HHS should be required to consult with affected physician specialties on defining what will be considered a "routine" visit for their specialty until the study is completed. Physicians should also be held harmless for billing practices that were in compliance with the practices and policies of the carriers at the time the service was rendered. Once the new refined codes are completed, specific direction should be given to carriers on the levels of service that appropriately should be recognized by the carriers as constituting "routine" visits for each specialty.

REDUCING ADMINISTRATIVE BURDENS

The issue of reducing the administrative burdens placed on physicians by the Medicare program should be on Finance Committee's agenda for ongoing consideration. Although not exclusively payment-related, many of the administrative burdens imposed on physicians have come about as part of efforts to reform the payment system. Many more such requirements may come about as a result of implementation of the new payment system. The requirements that physicians file all claims for beneficiaries and use ICD-9 codes are two examples of administrative requirements that were recently mandated by Congress.

Judging from the letters, phone calls and resolutions from ASIM members, the administrative burdens—or hassles—associated with the Medicare program and other payers are now the biggest concern of internists, even exceeding concern over inequitable payment. Physicians are tired of review programs that require them to justify every decision they make on behalf of their patients, but that seem incapable of disciplining those physicians who are truly abusing the program. They are tired of having to go through reconsiderations and appeals in order to get paid for their services. When they win on reconsideration, they know it has no long-term benefit, since the next claim for the same service, on the same patient, with the same diagnosis, will still be denied. They are frustrated with rules that change every day. They are concerned with the program's indifference or hostility to professional input. They are angry about a never-ending deluge of new requirements—some well-intentioned, many not—that have no relationship to the way medicine is really practiced, or that are extremely costly or difficult to comply with.

Why should this matter to Congress? Because, as discussed earlier, if enough physicians become completely disillusioned with the Medicare program, patient care will suffer. Few would disagree that when factory workers, teachers, government officials, nurses, office workers or businessmen become frustrated, angry and disillusioned with their jobs, their productivity and commitment diminishes. The same, of course, is true for physicians. The medical profession's commitment to their patients so far has protected the public from any harm that otherwise would have resulted from the government's policies. But if the administrative burdens required to serve Medicare patients increase unabated, ASIM has no confidence that this will continue to be the case in the future.

CONCLUSION

In conclusion, let me commend you again on what you have already accomplished. Enactment of the Medicare fee schedule is an historic achievement. But the final

verdict on this reform will depend on how it is implemented. ASIM urges the Committee to:

- Reject the administration's attempt to rationalize further cuts in Medicare Part B as being consistent with long-term reform. Congress should preserve the intent of OBRA '89 by rejecting proposed cuts that would undermine the gains in reimbursement for undervalued services expected of the RBRVS fee schedule.
- Oversee how the conversion factor is developed by the administration, so that undervalued services and localities receive appropriate increases under the new fee schedule. "A priori" assumptions of major volume increases should be rejected.
- Reject separate volume performance standards and conversion factor updates that will lead to new inequities and fragmentation of the profession's collective response to the volume issue.
- Direct the administration to desist from arbitrarily downgrading reimbursement for "routine" visits that are billed at a higher level than brief or limited. A moratorium on such downcoding should be mandated until HHS has consulted with physician specialties on how routine visits will be defined and until the AMA/PPRC coding study is completed.
- Put the issue of physician disillusionment with Medicare's administrative burdens on your agenda for future hearings and legislation. Failure to do so jeopardizes the professional heritage of the next generation, and perhaps the one after that.

Based on the administration's own record, ASIM has little confidence that the administration intends to implement the RBRVS fee schedule mandate in the manner intended by Congress. We hope we are wrong. But by providing appropriate oversight and rejecting ill-conceived budget cuts, this committee can help assure that the benefits of the reform are not abandoned in the process of implementation, notwithstanding the administration's true objectives. ASIM has confidence that the members of this committee are committed to bringing to fruition the more equitable reimbursement system for which we have all fought so long.

Prepared Statement of Carol McCarthy

INTRODUCTION

Mr. Chairman, my name is Carol McCarthy, president of the American Hospital Association (AHA). On behalf of AHA's nearly 5,500 member hospitals, I am pleased to testify on Fiscal Year (FY) 1991 budget proposals affecting hospital payments under Part A of the Medicare program and affecting Medicaid.

During budget deliberations last year, Congress acknowledged hospitals' increasingly fragile situation and the toll that years of Medicare cuts and Medicaid payment shortfalls have exacted. We appreciate your Committee's recognizing that ever greater demands are being made of hospitals, that Medicare payments fall further below actual costs with each passing year, that meager Medicaid payments are only partially covering care for the poor, and that rising unsponsored care costs are increasingly difficult for many hospitals to bear. With its efforts to temper proposed Medicare spending reductions last year, Congress signaled an understanding that hospitals have contributed disproportionately toward Federal deficit reduction. AHA also applauds the Medicaid expansions in the area of coverage for pregnant women and children. This year, however, Congress and hospitals face an even greater challenge as the Administration seeks to save billions more in Medicare spending reductions.

The Administration proposes tax increases and spending reductions totaling $36 billion in FY 1991. Of that amount, Medicare would absorb $5.6 billion in reductions. Breaking it down further, $3.4 billion would be taken from Part A payments to hospitals and, of another $2.2 billion that would come from Part B, more than $700 million would affect hospital outpatient payments. The budget proposal would require hospitals to absorb $4.1 billion in total reductions.

Medicare expenditures constitute approximately 8 percent of total Federal outlays, but cutbacks in Medicare payments in the Administration's budget for FY 1991—$5.6 billion—constitute about 36 percent of total proposed spending cuts.

The Administration's budget does not propose any mandatory expansions for the Medicaid program. The budget does propose a modest managed care initiative and recommends $25 million in new spending authority.

The past six years have seen substantial Medicare funding cuts, and hospitals have contributed more than their fair share to deficit reduction. Too many hospitals

have reached the point at which their ability to continue providing high-quality care to our most vulnerable citizens is at risk.

AHA is also troubled that government continues to limit payments to hospitals even though payments from the Hospital Insurance Trust Fund are financed through dedicated revenues. In fact, Medicare Trust Fund reserves are used (as are Old Age, Survivor, and Disability reserves) to mask the deficit's size by offsetting losses in the operating budget.

FINANCIAL STATUS OF HOSPITALS

Hospitals need Congress' continued support in FY 1991. They are in a precarious financial position. Overall patient operating margins in FY 1990 are hovering around zero percent, and the aggregate Medicare PPS operating margin is expected to be between negative 7 percent and negative 9 percent. AHA projects that for FY 1991, aggregate PPS operating margins, before proposed cuts, will decline further, ranging from negative 8 percent to negative 11 percent.

Medicare payment policies are having a deleterious effect on all types of hospitals. In 1991, before proposed cuts, more than 70 percent of hospitals are projected to suffer losses treating Medicare patients. More than half of all hospitals will have PPS deficits of 10 percent or more, and one-fourth will have PPS margins of negative 25 percent or more.

Sinking PPS margins suggest that hospitals are subsidizing care for Medicare patients through other payers. This raises questions about the strategy underlying Medicare payment policies and the effects these policies are having on the entire health care system. Some may believe that Medicare cuts affect providers only, or Medicare beneficiaries only, but duality and accessibility of care throughout the system are at issue.

Because Medicaid payment levels in most states fall far below cost, hospitals with large Medicaid populations generally experience substantial payment shortfalls. When added to the increasing burden of uncompensated care that most of these hospitals face each year, these shortfalls jeopardize the survival of those hospitals that serve a disproportionate share of the poor. Hospitals serving a large number of persons with AIDS (PWAs) provide a striking illustration of this problem. Because 40 percent of PWAs eventually become eligible for Medicaid and because AIDS is a particularly expensive disease to treat, Medicaid underfunding seriously undermines the financial stability of hospitals providing care to large numbers of PWAs.

The gap between revenues and expenses cannot continue to widen without dire consequences. Despite years of declining margins and mounting Medicare and Medicaid payment shortfalls, hospitals so far have maintained their long-standing commitment to providing high-quality care to patients wherever and whenever needed. But many hospitals may no longer be able to meet this commitment if reductions proposed in the FY 1991 budget are enacted. Many hospitals already have been forced to make difficult choices regarding the services they offer. To remain viable, many have had to close needed community services, including trauma care, obstetric, and other units.

AHA projects that the effect of two of the President's proposals—reducing the PPS update factor and the indirect medical education (IME) adjustment—would be to depress PPS operating margins in FY 1991 to at least negative 12 percent and as much as negative 15 percent. A full accounting of the effect of all proposed cuts would lower PPS margins even more. The package of cuts would result in a 6 percent reduction in Medicare hospital payments in FY 1991. Several years and many billions of dollars of payment reductions already have occurred. The New England Journal of Medicine reported last year that Medicare payments to hospitals in FY 1990 were already $18 billion less than it is projected they would have been in the absence of PPS.

These reductions would come at a time when the pressures facing hospitals are greater than they were a year ago. Costs of goods and services used to render the quality of care expected by the American public are increasing rapidly, even as unsponsored care for the uninsured and underinsured grows. In addition, many hospitals are reimbursed for care provided Medicaid patients at levels far below the cost of providing the care. These reimbursement shortfalls are particularly pronounced in the case of outpatient care, resource-intensive services such as trauma and neonatal intensive care, and care for AIDS patients.

The $4.1 billion in cuts from projected spending for FY 1991 would hurt all hospitals, but the greatest harm would fall on teaching facilities. Cuts affecting all hospitals include a 4.1 percent update factor (about 1.5 percentage points less than projected inflation), limits on payment for capital-related expenses, and lower payments for outpatient services. In addition, for teaching hospitals, the President would

lower IME payments, cap the intern- and resident-to-bed ratio at FY 1989 levels, and cut graduate medical education payments.

Further cuts in Medicare payments for hospital services to the elderly and disabled at this juncture also would add to the uncertainty and unpredictability that have come to characterize PPS.

FACTS ABOUT RISING HOSPITAL COSTS

As the downward trend in PPS aggregate margins indicates, increases in costs of providing hospital services to Medicare beneficiaries annually eclipse increases in Medicare payments. Unfortunately, the Administration's budget is based on the faulty assumption that hospitals are responsible for cost increases and can afford to absorb cuts through operational efficiencies.

In fact, hospitals have managed and are managing costs under severe financial constraints. They are doing so without compromising access to and quality of care. For example, hospital spending as a percent of gross national product has remained constant at about 4 percent since 1982, and real annual growth in hospital spending has been held to about 2 percent since 1985. Hospital expenditures have been the slowest growing component of personal health care spending since 1982.

In addition, hospitals have moved to provide care in the most efficient and appropriate settings. Outpatient visits now exceed the number of inpatient days of care in hospitals. Much of the decline in inpatient use and the complementary increase in outpatient care is the direct result of incentives by PPS and private insurers. Hospitals and medical staffs now are encouraged to emphasize cost efficiency in treating patients. The shift from inpatient to outpatient care also was facilitated by the phenomenal technological changes of the past decade, allowing hospitals to treat more illnesses on an outpatient basis. Nearly one-half of all surgeries are now performed on an outpatient basis, up from less than one-fourth just a few years ago.

Along with this shift to outpatient care, hospitals have modified inpatient capacity, reducing community hospital beds 71,000 or 7 percent since 1983 and cutting the time inpatients are hospitalized. And even though hospitals today are treating more acutely ill patients who require more technologically complex care, they are doing so more efficiently. Hospitals have held the aggregate staff-to-patient ratio constant since 1982. Considering the more seriously ill inpatient population, staff productivity has improved since 1982, and hospitals are managing costs better.

But costs are increasing, largely because of factors beyond the control of hospital management. Prices hospitals pay for resources (especially wages) needed for patient care are rising faster than prices in the rest of the economy. The Consumer Price Index climbed about 29 percent from FY 1982 through 1989, but the PPS hospital market basket index increased 36 percent. But the PPS market basket index still understates the rate of inflation hospitals face. The indicator Medicare uses to measure increases in hospital labor prices fails to accurately capture these changes because it is based, for the most part, on wages in other parts of the economy that are unrepresentative of hospital wage structures. Hospitals face shortages of essential personnel, particularly nurses and other technical staff, that have forced wages and benefits up faster for hospitals than for other businesses. AHA estimates the PPS market basket index understates the actual rate of hospital inflation 2 to 3 percentage points per year.

Today's typical inpatient also requires more intensive treatment than the typical patient five years ago. Patients requiring less complex and, therefore, less expensive treatment are now cared for on an outpatient basis. Likewise, those now admitted as inpatients are more expensive to treat, often needing more procedures and a higher level of skilled support personnel. Nonetheless, hospitals still have improved staff productivity.

In addition, patients are receiving new and better treatments. While advanced technologies yield substantial benefits in the form of reduced pain or risk, many have also added significantly to the cost of care. In most instances, these additional costs are not reflected in rates paid to hospitals.

Projected growth in Medicare spending is subject to the same cost pressures, pressures largely beyond the control of hospital management. In FY 1991, Medicare spending for hospital insurance benefits is expected to increase 9.2 percent. Of this, 5.6 percent is attributable to inflation or higher prices hospitals must pay for labor, drugs, and medical supplies. The number of beneficiaries eligible for Medicare Part A benefits is expected to grow 1.7 percent in 1991 as the population continues to age. If the population continues to spend the same amount per person as the current population spends, one could expect a relatively proportional increase in Medicare outlays. Another 1.5 percent of growth in Part A spending is attributable to FY 1991 expiration of the current 15 percent reduction in capital payments, assumed in

baseline Medicare spending estimates. The remaining growth is attributable to an increase in the Medicare case-mix index, which measures the increase in *payments and costs* of treatment resulting from the changing mix of patients admitted to hospitals.

The rationale underlying the Administration's budget fails to recognize these external cost pressures. Rather than reflect legitimate needs of Medicare beneficiaries, it forces hospitals and their medical staffs into a position of having to ration care. Hospitals cannot continue to provide more care with fewer resources. Inadequate hospital payments can mean that a necessary procedure cannot be provided, and that someone does without care they want or need. It is unconscionable to expect hospitals to dictate whether someone receives medical care on the basis of economic considerations. By underfunding health programs for the poor, aged, and disabled, government is shifting responsibility for assuring access to high-quality care for these groups onto the shoulders of hospitals.

As a result, signs of a deteriorating hospital system abound. Growing numbers of uninsured and underinsured Americans translate to an escalation in unsponsored care. In 1988, hospitals provided $8.3 billion in such care, up from $3 billion in 1980. Convincing other payers to share those costs has become more difficult.

Another major problem for hospitals, in part related to unsponsored care, is provision of trauma care. Availability of specialized trauma care has diminished in recent years, particularly in urban areas, as the combination of start-up and annual operating costs and poor payment has become too great a burden for many hospitals to bear. Many trauma victims are uninsured or rely on Medicaid, which usually does not cover costs. Consequently, many hospitals have had to choose between closing trauma centers or discontinuing other services.

BUDGET PROPOSALS: IMPACT OF CUTS

Against a backdrop of continued, largely uncontrollable financial and demand pressures on hospitals, the President proposes $4.1 billion in further reductions in growth of Medicare payments to hospitals. Adequate Medicare payments are essential to hospitals' financial stability and their ability to provide quality care. Medicare and Medicaid account for nearly half of gross patient revenue, and hospital operating margins follow the pattern of Medicare PPS margins, suggesting that inadequate Medicare payments are a key cause of hospitals' financial troubles.

The President's proposed package includes the following cuts for FY 1991:

- A 4.1 percent update factor for all hospitals (less than the rate of inflation);
- A 15 percent to 25 percent cut in payments for capital-related expenses;
- A 10 percent reduction in hospital outpatient payments; and
- A reduction of the indirect medical education adjustment (IME) to 4.05 percent.

The President's proposed Medicaid managed care initiative would:

- Provide enhanced Federal matching rates for states to promote use of managed care over traditional fee-for-service arrangements;
- Allow states to implement managed care programs without applying for a waiver; and
- Relax enrollment requirements for certain Medicaid HMOs.

Inadequate Update Factor

The President proposes to save $640 million in FY 1991 by limiting the increase in the FY 1991 update factor to 4.1 percent for all hospitals, whether urban or rural. This is about 1.5 percentage points less than the currently projected increase in the FY 1991 market basket index.

As in previous years, this update would fall short of the projected rate of inflation faced by hospitals. More troublesome, this proposal departs from the long-standing practice of using the market basket index to determine the update factor. Instead, the update factor would be set arbitrarily, a precedent that would effectively divorce hospital payment from actual economic conditions.

The President's budget proposal fails to recognize the need to continue to move, at least incrementally, toward elimination of the standardized rate differential. AHA continues to support a single base rate for all hospitals. AHA recommends providing payments above the rate of inflation for rural hospitals in order to move the system toward eliminating the disparity between payments to rural and urban hospitals and applauds the Ranking Minority Member, Senator Packwood, for his legislation, S.2214. In addition to eliminating the differential in FY 1991, the bill would also address many of the other problems facing rural health care providers.

Cuts in Payments for Capital-Related Expenses

The largest spending cut in hospital payments in FY 1991, $1.5 billion, would be achieved by maintaining the current 15 percent reduction in capital payments to rural hospitals and increasing to 25 percent the reduction in that payment to urban hospitals. Capital payments would be reduced for both inpatient and outpatient departments. The President's plan also assumes that payments for capital will be incorporated in PPS beginning in FY 1992.

Paying hospitals less than the full cost of capital is not an incentive to evaluate capital investments more judiciously. Capital decisions are driven by patient care considerations. Today's capital-related expenses result from previous years' investment decisions made in compliance with existing laws and regulations. Past obligations, unlike current operating expenses, are not subject to modification. The President's proposal turns all capital acquisitions into losing propositions, with concomitant effect on patient care. Such cuts, coupled with other proposed budget changes, also will erode hospitals' creditworthiness, inhibiting their ability to finance capital needs.

Reduced Payment for Hospital Outpatient Departments

Payments for hospital outpatient services would be reduced 10 percent across-the-board beginning in FY 1991, and reductions would continue each year. PPS, however, already provides incentives for hospitals to treat patients more efficiently. Hospitals have responded to those incentives by moving patients to outpatient settings when possible, resulting in perhaps the most significant health care trend of the 1980s. This major shift in the setting of health care services has yielded dramatic declines in hospital inpatient days and increases in outpatient visits. Coupled with improved technology, it means that today many procedures can be completed quickly, efficiently, and cost effectively, with benefits accruing to providers, payers, and patients alike.

The proposal to cut outpatient payments flies in the face of incentives Congress emphasized in creating PPS and the peer review organization program. ProPAC estimates that hospitals already are subject to potential losses of 19 percent under ambulatory surgery center payment rates. Further increasing proposed cuts sends a conflicting message to hospitals as they follow Medicare's directive to deliver care in the most efficient settings.

Reductions in outpatient payments will have a severe impact on rural hospitals. In addition to following the incentives of PPS, rural hospitals have taken the opportunity to shift more and more patients to outpatient settings as part of their reconfiguration efforts. Outpatient services have become a mainstay of hospital care in rural communities, enabling hospitals to remain open and ensuring access to care.

Lower Indirect Medical Education Adjustment

Teaching hospitals would be hardest hit by the budget proposals. These hospitals are responsible for proper training of future medical professionals and are often at the cutting edge of innovative medicine. They also tend to serve more acutely ill patients and a larger share of indigent and low-income patients. These services already are recognized with a PPS payment adjustment. Teaching hospitals' Medicare margins historically have been higher than Medicare margins for other types of hospitals, primarily because of the special adjustment. However, when compared to other hospitals on the basis of total performance, teaching hospitals fare poorly, reporting the lowest total margins of all hospitals. The President's proposals would further depress margins for teaching hospitals. In FY 1991, PPS margins would reach a low of negative 13 percent to negative 16 percent.

The factor used in making IME payments to hospitals would be reduced from 7.7 percent to 4.05 percent. Such a reduction would exacerbate teaching hospitals' vulnerable financial situation and could affect access to care, particularly for the large numbers of indigent and low-income patients they serve.

The IME adjustment is essential to the survival of teaching hospitals. It was intended not only as a means of compensating these facilities for additional costs associated with teaching programs, but also to adjust for additional costs attributable to more seriously ill, more expensive to treat patients, for whom DRGs do not fully account. In FY 1989, margins for major teaching hospitals would have been four times lower, negative 30 percent, without the IME adjustment. The American Association of Medical Colleges attests to declining margins for teaching hospitals. AHA data show that PPS margins for teaching hospitals have declined dramatically since FY 1986. Furthermore, AHA projects that in FY 1991, with no changes in current hospital payment policy, the average teaching hospital will have a PPS margin of negative 9 percent. If the President's IME proposal were enacted, the average teach-

ing hospital's PPS margin would drop to negative 14 percent. This translates to an average loss for teaching hospitals of $300 per Medicare patient.

AHA RECOMMENDATIONS AND CONCLUSIONS

Proposals to restrict Medicare payments worsen hospitals' already perilous financial condition. Current payments for services fail to cover costs of treating Medicare patients. Medicare patients receive the same high-quality care as private paying patients, yet the Federal Government pays substantially less than the costs of care. Fair government payment for hospital services is essential. To that end, on behalf of AHA, I offer some specific recommendations for improvements in inpatient and outpatient payment policy under Medicare.

Medicare Inpatient Payment Policy

Prices should be recalculated based on costs defined to include elements of uncompensated care expenses and a return on investment. Between recalculations, standardized amounts should be updated by the rate of increase in market basket inflation. This price-setting method ensures predictability for hospitals and maintains PPS cost-containment goals by preserving incentives for cost-effective and cost-efficient delivery of care.

A single "base" rate (elimination of urban/rural rate differential) should be set for all PPS hospitals and be adjusted for patient characteristics, differences among hospital markets in prevailing resource prices, and variations in resource use that are beyond hospital management control. Such a rate would pay hospitals based on types of patients treated and resources used and would take geographic location into account only to adjust for variations in resource prices. Movement to a single-rate system should include a hold-harmless provision that protects hospitals from payment reductions resulting solely from movement to a single rate.

A revised hospital market basket index, whose labor component is based solely on hospital wage inflationary trends rather than trends in other sectors of the economy, should be adopted.

Problem DRGs should be refined to improve PPS sensitivity to differences in patient characteristics. Refinement is needed for DRGs that account for a high volume of Medicare admissions and that show substantial differences in costs among hospitals, or that contain diagnoses or procedures that differ substantially from the average of other diagnoses or procedures included in the DRG, or that have been identified as incorrectly classified by hospitals or physicians.

A comprehensive index should reflect variation in prices hospitals pay for all types of resources, labor and nonlabor, especially energy/utilities and liability insurance. Pending enactment of a non-labor adjustment, regional payment floor provisions due to expire Oct. 1, 1990, should be extended.

Swing-bed opportunities should be expanded to all urban and rural hospitals for transitional care/skilled nursing care for Medicare beneficiaries.

Medicare Outpatient Payment Policy

A Medicare outpatient payment system should be established based on per-procedure average operating cost limits (based on hospital costs only, by region) as a transition to a procedure-based fee schedule.

Exception or exemption opportunities should be provided for sole-source providers in both urban and rural settings.

It should be assured that legitimate cost differences across settings and procedures are identified and taken into account for various types of outpatient services in establishing the system of per-procedure cost limits and ultimately a per-procedure fee schedule system.

Medicaid Policy

Substantial Medicaid reform is needed to make the program responsive to recipients' needs. Congress should look toward development of a minimum payment standard to assure that all Medicaid payments for services come closer to meeting the cost of providing them so that every recipient has reasonable access to any necessary hospital treatment in a timely fashion.

Further, Medicaid should be decoupled from cash assistance programs and moved toward Federal financing with uniform eligibility standards and coverage. Elements of a restructured Medicaid program should include:

- A minimum national Medicaid eligibility floor, set at 100 percent of the Federal poverty level and providing for an orderly phase-in for moving the national floor to 100 percent of poverty; and

• Phased in, required coverage of pregnant women, infants, and children up to 185 percent of the poverty level.

Reform in eligibility policy, enrollment incentives, financing and reimbursement, and service coverage also are required to address Medicaid shortcomings. Many of the poor are eligible for Medicaid coverage but not enrolled, largely because proving eligibility is too complicated and burdensome. Medicaid's full potential cannot be realized without uniform, simple procedures for eligibility determination. Outreach hospital enrollment programs would be one way to close the enrollment/eligibility gap.

For the long term, AHA recommends expansion and revision of the Medicaid program into a separately funded and administered program with three parts, each with distinct funding sources:

- Acute care coverage for the medically indigent not eligible for Medicare;
- Supplementary acute care coverage for Medicare beneficiaries; and
- Long-term care coverage for low-income individuals.

CONCLUSION

AHA trusts that in addressing the immediate task of meeting deficit reduction targets, Congress will not lose sight of long-term consequences that yearly budgetary decisions have on the delivery of health care services. Providing health care for the aged, disabled, and poor helps maintain our social safety net, but budget-driven decisions threaten to compromise that commitment. Hospitals cannot continue to sustain Medicare payment reductions and redistributions and inadequacies in Medicaid payments of the magnitude of those in previous years, but must, instead, have adequate, equitable, and predictable payment systems.

RESPONSE TO A QUESTION SUBMITTED BY SENATOR BENTSEN

Question. Dr. McCarthy, your statement indicates that hospitals and medical staffs are encouraged to emphasize cost efficiency in treating patients. Physicians have a large impact on hospital costs by ordering lab tests, x-rays, and other services. A recent issue of *Hospitals* magazine reports that some hospitals have had success in controlling cost by providing individual physicians with information about how their use of hospital resources compares with other physicians treating similar patients. Yet, it is a minority of hospitals—only about 25%—that are taking this type of approach. Given the financial pressure they are under, why aren't more hospitals taking this approach? Are there steps we should be taking legislatively to encourage more hospitals to work with their physicians this way?

Answer. It would be premature, given the current state of knowledge and the resources available to hospitals, to require that hospitals profile physician resource use. Legislation requiring such profiling would be out of step with the conclusions of much current health services research with respect to the most productive way to focus data development and analysis. Researchers in this field believe that better physician practice guidelines are the key to more efficient use of health services.

Congress took an appropriate first step last year when it created the Agency for Health Care Policy and Research to encourage the development of data bases, research methods, and appropriateness standards that can be used to improve the efficiency and quality of care in hospitals. Congress should take the next step now and consider (a) assuring adequate access to capital so that hospitals can upgrade their computer capability, (b) grants to hospitals to improve their data systems, (c) support for private sector development of physician practice guidelines, and (d) increased funding for research to develop ways to integrate hospital data systems, to improve data feedback to physicians, to adjust data for patient risk, and to effect appropriate changes in physician practice.

The *Hospitals* survey did show that half of responding hospitals already do some sort of physician profiling. However, as the question states, fewer than 25 percent of all hospitals share physician profiles with their physicians. This could well reflect the opinion of some administrators that resource use is not affected by physician practice patterns (as opposed, say, to patient needs or hospital factors). Hospital administrators also may not believe that simple feedback of profiling data is the most efficient way to change physician behavior.

The hospital industry is beginning to look at adopting "continuous quality improvement" management practices which aim at reducing internal variations in resource use. Technical limitations prevent many hospitals from profiling physician resource use, including lack of integrated data systems, computer hardware, and trained data analysts. In addition, hospitals need (a) a sizeable and representative

comparison group to generate meaningful comparative data that represent physician practice, (b) sufficient clinical information to adjust for differences in patient condition, and (c) reliable information about treatment outcomes in order to assess the impact of the variations in resource use. The AHAs Hospital Research and Educational Trust, through its Quality Measurement and Management Project, is developing ways to supply hospitals with meaningful comparative data as well as the management tools needed to use such data to improve patient care. Yet we expect it to be several years before we have everything required to make this a viable practice.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I appreciate your holding today's Finance Committee hearing to examine how the President's budget proposal would affect health, income security, and social service programs. As Chairman of the Senate Special Committee on Aging, I would like to take this opportunity to briefly discuss how this budget proposal would affect older Americans.

President Bush's FY 1991 budget is similar in many ways to his predecessor's. As were the Reagan budgets in previous years, it is full of very optimistic economic assumptions that minimize the actual size of the deficit. According to the Congressional Budget Office, OMB's projections understate the FY 1991 deficit by $70 billion.

The Administration's budget also slashes many of the same programs that were targeted in the past for spending cuts. The greatest amount of deficit reduction comes from entitlements and other mandatory spending. Over one-third of the President's deficit reduction comes from domestic programs, many of which have been already cut to the bone. According to CBO, domestic spending overall is reduced by $13 billion in FE 1991, with these cuts coming from the Medicare program, retirement COLAs, Veterans' services, food and nutrition programs, etc. In other words, those programs aimed at helping many of our most vulnerable citizens—children and the elderly.

A close look at some of the Administration's policies leave many wondering if the right hand knows what the left hand is doing. Their budget proposal would cut Medicare by more than $5 billion. Yet the President has asked both Secretary Sullivan and the Steelman Commission to examine ways to expand access for the uninsured and long-term care for the elderly and disabled. The President's proposals for defense spending are even more confounding. Many Americans thought that the changes in Eastern Europe and the Soviet Union would bring with them a "Peace Dividend," a cut in defense spending that could be used to bolster many of our domestic programs. Unfortunately, the Peace Dividend does not exist. On the contrary, the President's budget cuts defense spending by a mere $3 billion.

The $5.1 billion in Medicare cuts are aimed primarily at providers through reductions in payments for capital, for the indirect costs of medical education, and for outpatient department services, as well as a lower-than-anticipated PPS update. Payments to physicians will be cut some $1.1 billion. The Administration is once again using the tired argument that cuts aimed at providers do not harm beneficiaries. However, it has become apparent that asking providers to continue to shoulder the burden of Medicare cuts will ultimately affect beneficiaries' access to health care services.

Although most of our attention regarding health care is usually devoted to the Medicare program, particularly during budget deliberations, I am also concerned about the Medicaid program. As my colleagues on the Finance Committee know, I am deeply concerned about the ordeal that States face in attempting to try to get a fair deal for prescription drugs for low-income Americans under the Medicaid program.

We have committed ourselves to containing costs as best we can, as evidenced by the budgetary decisions we have made over the past few years. Federal and state health budget cuts have fallen on virtually all parties: Beneficiaries, hospitals, doctors, nursing homes, pharmacists and others. There is one exception, however the drug manufacturers.

As a result of a year-long investigation that the Special Committee on Aging has conducted, it is clear that not only have the manufacturers evaded cost-containment efforts, but that their prices have soared dramatically. Between 1981 and 1988, while the CPI increased 28 percent, prices for prescription drugs increased by 88 percent. And, the drug industry is no small Medicaid beneficiary: By 1988, Medicaid paid $3.3 billion for prescription drugs—more than for physician payments.

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Many States have attempted to negotiate with manufacturers to get the same prices for prescription drugs that hospitals and health maintenance organizations have been able to get for years, using standard prudent business practices. Yet, nearly all attempts have been utterly rebuffed by the manufacturers. They evidently do not believe that the taxpayer is entitled to the same prices that hospitals, HMOs, and others get.

As my colleagues on the Finance Committee know, I intend to offer legislation to ensure that the Medicaid program is treated equally by the manufacturers in negotiating fair drug prices. This will give us the opportunity to save some $300 million in the Medicaid program. I look forward to working closely with Secretary Sullivan and HCFA Administrator Gail Wilensky to accomplish just that.

Medicare and Medicaid are not the only areas affected by the President's budget proposals. With respect to Supplemental Security Income (SSI), the Bush budget would charge States a total of $55 million in the coming fiscal year, an amount that will increase to $165 million annually by fiscal year 1993, in new administrative fees. The costs of the fee would likely be passed onto program beneficiaries—those least able to pay—through reduced assistance.

When only half of those eligible for SSI—a program of financial aid to disabled and aged individuals living in poverty are actually participating in the program, the Bush budget would provide no additional resources for program outreach. Last year I introduced legislation to require that the Social Security Administration (SSA) establish an SSI outreach program. Also, SSI outreach has been a stated priority of SSA Commissioner Gwendolyn King. Without needed resources, how can the new Commissioner be expected to fulfill this objective?

The President's budget also proposes dramatic cuts in social services, such as the Community Services Block Grant CSBG). Recycling a previously rejected proposal, the Bush budget would virtually eliminate the CSBG program, which serves as the lifeline to an array of programs across the nation providing health, nutritional, and employment assistance to the poor, elderly, and infirm. President Bush does not make up for these cuts anywhere else: he proposes only a meager increase in Social Services Block Grant spending. The low-income home energy assistance program, (LIHEAP) would also be cut. LIHEAP faces the sixth consecutive year of cuts; it would lose $365 million in funding, which represents a reduction of 25 percent.

Mr. Chairman, the Aging Committee staff has prepared an information paper summarizing the President's FY 1991 budget proposals as they relate to programs serving older Americans. Senator Heinz and I are pleased to release it today. I would like to request that the executive summary of this paper be placed in the record after my prepared remarks.

The staff report details the extent to which the President relies on vulnerable populations of Americans to shoulder budget cuts. These Americans are not selfish people. They are willing to do their fair share when it comes to deficit reduction, but they will not and should not accept being disproportionately singled out. If we are going to be serious about reducing the budget deficit, everyone must contribute. So far, the President has not illustrated any willingness to support comprehensive budget reduction approaches that meets this criteria. It is time to rethink that position.

The miracles that have been occurring around the world over the past several months should inspire us to reassess our priorities. We now have far more dangerous enemies to fight—poverty, hunger, drugs, and disease, to name but a few. I hope we can count on the President to be our ally, and not our opponent, in this battle.

President Bush's Proposed FY 1991 Budget for Aging Programs

[Senate Special Committee on Aging Staff Report, March 1990]

PREFACE

This information paper, prepared by the staff of the United States Senate Special Committee on Aging, analyzes the full range of fiscal year 1991 budget proposals affecting older Americans. It outlines President Bush's proposed budget, regulatory initiatives, and legislative reforms for aging programs for the coming fiscal year. Included are the proposed budgets for Medicare and Medicaid; income and retirement programs; Veterans benefits; health and social service programs; and education, training and research programs.

In each program area, the proposed spending and revenue levels for FY91 through FY93 in the Bush budget are analyzed against current service projections, as measured by the Office of Management and Budget and the Congressional Budget Office, where available.

SECTION I.—HIGHLIGHTS OF BUDGET PROPOSALS AFFECTING AGING PROGRAMS

Many of the President's initiatives for aging programs have been proposed by the former Administration and rejected by the Congress. Other Bush proposals are extensions of savings and revenue initiatives which have already been enacted into law. Major cuts are targeted at Medicare ($5.2 billion), housing ($210 million), low-income energy assistance ($264 million), Senior Community Service Employment (Title V of the Older Americans Act, at $29 million), Community Services Block Grant program ($363 million), and civil, military, and railroad retirement benefits ($2.1 billion).

Previous Proposals: Reductions in payments to Medicare providers (extensions and deeper cuts in provider payments along the same lines as the Omnibus Budget Reconciliation Act of 1987); extension of Hospital Insurance (HI) payroll tax (and Medicare coverage) to all state and local employees; cuts in medical education, housing, energy assistance programs; the elimination of selected health, social service, legal aid, professional training, and housing programs; and the elimination of the Federal retiree lump-sum pension option and a one-year freeze, followed by a reduction, of the COLA for Federal civil and military retirees.

New proposals: Incentives to enroll Medicare and Medicaid beneficiaries in managed-care programs; and, establishment of a Family Saving Account Plan to promote savings and long-term economic growth.

BUSH BUDGET: FY 91—MARCH, 1990 CBO ESTIMATES

	Request	Current Services	Difference
	[In billions of dollars]		
MEDICARE	122.0	116.8	−5.2
Part A (HI)	64.5	67.5	−3.0
Part B (SMI)	47.2	49.3	−2.1
Reduce funding for Part A Capital, Indirect Medical Education, & PPS updates and Part B non-primary care physicians & overpriced procedures.			
MEDICAID	45.4	45.1	−.30
Increase spending by 12% over FY90 allocations. Enhance match for states that enroll Medicaid recipients in managed care, and beginning in 1992, reduce payments for states that continue to use traditional fee-for-service.			
	[In millions of dollars]		
Veterans Health	* 12,579	* 12,160	419
Increase pay for health professionals. Require co-payments for VA outpatient visits, prescription drugs, and cost recovery for treatment of non-service connected disabilities from service-connected veterans who have health insurance (savings of $112 million).			
* OMB number			
NIH	7,930	7,900	30
NIA	249	250	−1
Increase the NIH budget by $354 million above the 1990 level. Increase NIA budget by $9.4 million. Reduce number of new NIA grants (194 in 1989, 156 in 1990, and 153 in 1991). Direct 30% of grants for Alzheimer's research.			
HRSA	1,587	1,838	−251
Reduce grants for health care students, with the exception of minority programs which are expanded.			
SOCIAL SECURITY	265,800	265,800	0
No major benefits change. Raise $2.3 billion in FY 1991 by extending Social Security coverage to all state and local workers who are not covered under a different pension system and for D.C. employees hired after Jan. 1, 1991.			
SSI	14,632	14,447	185
Raise $55 million in FY91 by charging states a fee for the administration of their SSI supplemental program. 18 states affected. Also "paper" increase of $255 million in FY 91 as a result of accounting change.			
RAILAOAD RETIREMENT	4,372	4,435	−63

BUSH BUDGET: FY 91—MARCH, 1990 CBO ESTIMATES—Continued

	Request	Current Services	Difference
Privatize RR Retirement, eliminate Tier II COLA in FY 1991 and change Tier II COLA formula thereafter to a CPI–1 formula. Also finance 25% of Federal windfall through the rail pension trust fund (estimated savings of $80 million).			
FEDERAL CIVILIAN AND MILITARY RETIREMENT			
Civilian	31,905	33,996	−2,091
Military	22,335	22,976	−641
Eliminate FY 1991 COLA for Federal civilian and military retirees and reduce thereafter the COLA to CPI −1%. Civil service retirees can no longer remove their contributions as a lump sum.			
VETERANS COMPENSATION, PENSIONS, AND BURIAL BENEFITS			
Pensions	3,847	3,877	−30
Compensation	11,7961	11,934	−138
Burial	140	140	0
Make COLA automatic instead of annually legislating COLA. Assumes a January 1991 COLA of 3.9%. Save $171 million by placing a limit on estates of mentally incompetent veterans.			
PENSIONS BENEFITS			
PGBC	264	264	0
PWBA	90	77	13
No major changes for the Pension Benefit Guaranty Corporation (PBGC). Increase funding to Pension Welfare and Benefits Administration for more pension enforcement and protection activities.			
OLDER AMERICAN ACT	748	779	−31
Reduce funding for Title III programs (community-based services) by 4.0% and Title VI (Native American grants) by 3.7%			
COMMUNITY SERVICES			
CSBG	0.042	412	−363
SSBG	2,802	2,988	−188
Senior Employment (Title V of OAA)	343	372	−29
Eliminate Community Service Block Grants (except for a homeless program). Increase funding for Social Service Block Grants, but far short of the amount necessary to offset CSBG cuts. Cut FY 1991 funding for Senior employment by $29 million and freeze thereafter.			
ACTION VOLUNTEERS	121	123	−2
Increase stipend for Foster Grandparents from $2.15 to 2.35 per hour and maintain total service hours.			
HOUSING/ENERGY ASSIST.			
Section 202	220	430	−210
CHSP	0	6.3	−6.3
LIHEAP	1,100	1,463	−363
Reduce sharply section 202 elderly housing (from 8,368 units in FY 90 to 3,967 units in FY 91). Fund 3,000 units of leased housing. Eliminate Congregate Housing Services Program. Continue multi-year cuts ofLow-Income Home Energy Assistance Program (from a FY 85 funding level of $2.1 billion to a FY 91 funding level of $1.1 billion).			
TAX EXPENDITURES IN AGING-RELATED AREAS			
No major tax change in allowable deductions for health, housing credit, income security, and support for the aged and the blind. Tax deductions provided by the government for pensions ($57 billion in 1989) represents the single largest tax expenditure of the government. The third largest government expenditure goes to employer contributions for medical insurance premiums and medical care ($32.4 billion in 1989).			

Prepared Statement of John J. Ring

Mr. Chairman and Members of the Committee: My name is John J. Ring, MD. I am a physician in the practice of family medicine in Mundelein, Illinois. I am also Chairman of the Board of Trustees of the American Medical Association. With me today are Ross Rubin and Denise Andresen of the AMA's Division of Legislative Activities. The AMA is pleased to have this opportunity to testify before you regarding

the Administration's very serious proposals to cut up to $5.5 billion from the projected Medicare budget for fiscal year 1991.

Mr. Chairman, the AMA recognizes the necessity for the Congress to work to achieve the goal of a balanced Federal budget and to meet reconciliation targets assigned by previous budget resolutions. We know this Committee has made and will continue to make tough decisions about numerous programs. As you well know, the Medicare program has presented the Congress with many difficult decisions over the years, and has suffered massive cuts since the inception and continued use of reconciliation during the decade of the '80s.

This Committee, in its recent statement of "Views and Estimates" regarding the fiscal '91 budget, acknowledged the beleaguered status of Medicare, and made the following insightful statements:

> The Medicare program has over the past several years borne much of the burden of deficit reduction. While that program does represent a major element of Federal spending, it cannot continue to absorb major cutbacks without damaging the health care system in ways which will ultimately be harmful to the nation.

We heartily agree with the Committee.

The Administration's proposed fiscal year '91 savings, which come in the wake of the sweeping physician payment reforms enacted only three months ago, are not a solution to the high costs of health care. The proposed savings are not the product of a reasoned and deliberative analysis of how to provide better and more efficient health care to the nation's elderly and disabled. Rather, they are the result of arbitrary attempts to find savings no matter how great the cost.

This short-sighted approach, which may produce some immediate savings, threatens to undermine the physician payment reforms of OBRA-89, jeopardize the availability of quality health care for Medicare beneficiaries and overwhelm the physician community that is attempting to practice medicine while accommodating the massive payment and practice reforms just adopted.

The plight of physicians in today's budget-driven environment is aptly illustrated by the trilogy of articles published recently in The *New York Times*. Bearing titles such as "Changes in Medicine Bring Pain to Healing Profession" and "Practice of Medicine is Undergoing Change, Demoralizing Doctors," the message is clear: physicians are reeling from the inordinate payment and practice changes of the 1980s. As one of the articles explained, the

> feeling of being shackled by rules and overseers is nearly universal among doctors today, experts inside and outside the profession say. Doctors say they are overwhelmed by paperwork, prohibited by insurance companies from doing procedures and subjected to scrutiny by group employers like health maintenance organizations that can even include scheduling of restroom breaks.

As a result of these factors, the practice of medicine as we have known it is diminishing. Physicians are abandoning self-employment for salaried positions that spare them the burdens of start-up costs and office administration and the long hours associated with self-employment. This trend is especially disturbing for the underserved sector of the country, nearly three-fourths of which is comprised of rural areas.

Some physicians are forfeiting the practice of medicine altogether, and young Americans, daunted by the inordinate burdens of practicing medicine in today's environment, are rejecting medicine as a career choice. In fact, medical school applications have decreased 25% over the past five years. Physicians' concerns about professional liability issues and six-figure liability premiums go ignored, and Medicare rewrites the rule book every year.

As noted by Dr. William Roper (former Administrator of the Health Care Financing Administration, former Domestic Policy Advisor to the President and now Director of the Centers for Disease Control), the "growing disenchantment of the average doctor" is disturbing. To quote Dr. Roper, we should not treat doctors "as if we can abuse them and think we have lost nothing by it. I fear that the loss of faith by doctors will make them less caring and compassionate."

What is the relevance of all this to the budget-making process? As I stated earlier, it is not to say that budget savings are unnecessary or impossible. It is, however, the very relevant backdrop for your budget deliberations. We recognize, and the medical community recognizes, your need to find ways to curtail the escalating Federal debt. We urge you, however, to proceed cautiously in imposing additional cuts and

changes at a time when Medicare and the physicians that service the program are struggling to accommodate radical budget cuts and practice reforms.

The AMA is not alone in these concerns. On February 20, 1990, the AMA and 32 specialty societies published in *The Washington Post* "A Message to Congress on Medicare" expressing grave concern over the impact of further cuts on the Medicare program and its beneficiaries (attached as Appendix I). We urge you, Mr. Chairman, to proceed cautiously in imposing further cuts on this program. We also urge you, in evaluating the Administration's proposed cuts, to consider the following three points.

MEDICARE HAS HISTORICALLY BEEN SUBJECTED TO A MASSIVE SHARE OF FEDERAL BUDGET CUTS

The Medicare program has been subjected to over a decade of major funding cuts. Each major budget reconciliation bill has drastically reduced Medicare funding, as illustrated by the following table.

	Fiscal year	Medicare savings (Billions of dollars)
OBRA–82	1982	$3.2
TEFRA	1983	[1] 13.3
DEFRA	1984	6.1
COBRA	1986	[1] 4.3
OBRA–86	1987	3.0
OBRA–87	1988 & 89	5.9
TOTAL		35.8

[1] Over 3 years.

Additional cuts in fiscal year '91 will only exacerbate the inequity of Medicare shouldering such a massive share of Federal budget cuts, and, as the Committee noted, will be detrimental to our nation's health care system. Absent a determination to apply an across-the-board approach to freeze all Federal spending, we cannot endorse further Medicare cuts.

PART B OF MEDICARE HAS HISTORICALLY BORNE A DISPROPORTIONATE SHARE OF MEDICARE FUNDING CUTS

We challenge the erroneous assertions of the press and public that physicians have been relatively insulated from past budget cuts. Contrary to press statements that Part B is "the only place that hasn't experienced the crunch," the reality is that Part B has been subjected to significant cuts in the form of freezes and budget reductions. In fact, relative to respective program sizes, *Part B has absorbed a disproportionate share of the total cuts made in the Medicare program.*

That Part B has a long history of budget cuts is borne out by the following facts:

- Medicare reimbursement *and* fees were frozen for most physicians for 40 months from July 1983 to 1987;
- Medicare reimbursement for selected procedures was cut across-the-board by a total of 12% in 1987 and 1988, and special limits were imposed on physician fees for these procedures;
- The Medicare allowed amount for an office visit is only 79% of the amount actually billed by physicians to other patients (according to our 1989 survey); and
- Physicians presently are the only profession subject to Federal price controls, the maximum allowable actual charge program.

Both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. (A summary of recent actions limiting physician reimbursement and charges is attached as Appendix II.) The sum of the budget savings estimated by HCFA for ORA (1980), OBRA–81, TEFRA, DEFRA, COBRA, and OBRA–86 is approximately $18.2 billion for Part A and $13.4 billion for Part B (United States General Accounting Office, 1988).[1] This represents a 6.9% reduction

[1] This GAO study is the most recent study available. We urge Members of the Committee to request GAO to update the study.

in cumulative Part A outlays and a 10.9% reduction in cumulative Part B outlays. Thus, *relative to the respective program sizes, Part B was cut about one and one-half times more than Part A.*

In fact, *recent data obtained from HCFA show that, during the period from 1986 to 1989, the rate of increase of actual Medicare cash disbursements for physician services has been cut in half.* The same is true for total Part B disbursements during that period. By contrast, total Part A disbursements accelerated during this period and, for the first time in a decade, the Part A expenditure growth rate for 1989 exceeded the Part B rate (see Appendix III).

Nevertheless, in a $96 billion program, some savings can be found and revenues can be obtained. If there is to be no across-the-board measure, and if you decide that Medicare spending cuts are unavoidable, we believe that any reductions made in Medicare should be done in proportion to actual outlays.

THE PROPOSED FISCAL YEAR '91 CUTS WILL UNDERMINE THE LANDMARK PAYMENT REFORMS OF OBRA-89

Just three months ago, Congress enacted dual landmark physician payment reforms: the Resource-Based Relative Value Scale (RBRVS) and the Medicare Volume Performance Standards (MVPS). RBRVS supplants Medicare's historical "reasonable charge" method of physician payment with a fee schedule. MVPS will, for the first time, allow Congress and the profession to monitor the volume of physician services provided to beneficiaries.

As you know, the RBRVS methodology is the result of years of research and evaluation, and is designed to ameliorate the reimbursement inequities of the reasonable charge system. *RBRVS, which will take effect in 1992, is to be implemented in a budget-neutral manner.*

Implementation of RBRVS will have significant effects of transferring resources between medical specialties and geographic regions of the U.S. Congress crafted a five-year transition period to ameliorate any dislocations that these resource shifts might cause. In addition, although RBRVS is methodologically sound, it has not been implemented in any major setting. Therefore, caution is necessary so that we can understand the impact of RBRVS implementation and correct problems that arise during the transition period.

Despite the magnitude of the OBRA-89 physician payment reforms, the Administration proposed $2.2 billion in Part B cuts immediately after enactment. These cuts include:

- reducing payments for certain procedures and localities;
- allowing a full Medicare economic index update only for primary care services;
- reducing payment for radiology and anesthesia services; and
- reforming payments for assistants at surgery and surgical global fees.

By proposing these and other cuts,[2] the Administration is proposing to undermine RBRVS before the methodology is even implemented. The budget cuts eviscerate the concept of budget neutrality upon which RBRVS is premised by "chipping away" at the payment levels in effect when Congress enacted the fee schedule. Consequently, the fundamental goal of RBRVS—redistribution of resources—will be subverted; there simply will not be adequate funds available to transfer from one specialty or geographic region to another. As a result, individuals residing in underserved areas such as rural areas will likely remain underserved.

In addition to undermining the budget neutrality requirement of RBRVS, the proposed cuts are simply inconsistent with effective implementation of RBRVS and MVPS. These reforms are the product of innumerable hours of study, refinement and honing; it would be ultimately inefficient and disruptive to "tinker" with their foundations before they are implemented.

Although the proposed budget cuts are of paramount importance, they are not our only concern. We would like to take this opportunity to call to the Committee's attention several other vital issues. First, the OBRA-89 physician payment provisions contain a serious internal inconsistency. As stated previously, RBRVS will be implemented in 1992, and will base payment on the resources required to provide medical services. In addition, OBRA-89 replaced the existing Maximum Allowable Actual Charge (MAAC) program—which limits physician billings by a complex formula based upon 1984 actual charges—with a phased-in cap equal to a percentage of the RBRVS resource-based payment amount (115% by 1993).

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[2] A complete listing of the Part B cuts and the AMA's recommendations regarding those cuts is attached as Appendix IV.

The inconsistency in this scheme is that RBRVS will not be implemented until 1992, yet the billing limits, which are supposed to be based on RBRVS payments, will be implemented in 1991. For 1991 only, therefore, the cap will be 125% of the existing CPR system. The 1991 cap could cause serious reductions in the fees physicians are allowed to charge in 1991, especially the fees for the "undervalued" evaluation and management services, and services provided in traditionally under-compensated rural areas.

Although we do not believe that physicians should be subject to arbitrary billing limits, we recognize that the new system is designed to establish limits based upon defined amounts reflecting the shift between services and regions. We believe that the new system, however, is seriously flawed in that its implementation precedes implementation of RBRVS, and urge that legislation be incorporated in the pending reconciliation bill to delay implementation of the new billing system until 1992.

Second, we urge the Committee to expand the Medicaid program to cover infants, children, and pregnant women, and to establish uniform eligibility requirements. Medicaid currently covers only 40% of the poor, and expansion is essential to interrupt the "poor health of the poor" cycle that poverty perpetuates.[3]

Third, we urge the Committee to consider the extreme negative impact of Congress' treatment of student loans on access to health care. In 1986, Congress revised the tax code to eliminate by 1991 student loan interest deductibility. In OBRA-89, Congress eliminated the loan repayment deferral to which medical residents had previously been entitled during their residencies.

These two actions significantly affect access in two ways. First, hit with the dual penalties of nondeductibility and forced repayment during residency, many residents are now facing monthly loan payments of $500 to $700. This financial burden, quite staggering to residents typically earning $2200 to $2300 monthly, is forcing residents who would otherwise serve rural and other underserved areas to secure high-paying positions. The motivation is obvious: economic survival.

Congress' treatment of student loans affects access in a second way. Individuals contemplating medical careers likely will be dissuaded from pursuing them because the training necessitates incurring significant debt, yet the government forces repayment of that debt at a time when physicians have severely limited incomes. We urge the Committee to recognize that educational loans are investments in the future of this country's health care system, and eliminate the financial penalties placed on resident physicians.

Fourth, we alert the Committee to scrutinize the forthcoming regulations implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88). As detailed in Appendix VI, and based upon our review of an unpublished preliminary draft of the regulations, we are very concerned that the Department of Health and Human Services intends to adopt rules reflecting an inappropriate and unduly rigid interpretation of the legislation that will increase costs and lead to decreased access to services.

CONCLUSION

In conclusion, Mr. Chairman, Medicare has been subjected to years of significant budget cuts, and we have recently attained massive reforms in physician payment. Although we do not believe that RBRVS is a panacea for all physician payment issues, it is a well-grounded effort at achieving equity in reimbursement. We urge you to prevent the undermining of RBRVS, and to protect the program from further cuts that, if imposed, will jeopardize the health care of the nation's elderly and disabled.

At this time, we will be pleased to respond to your questions.

APPENDIX I.—A MESSAGE TO CONGRESS ON MEDICARE

As organizations of physicians whose members serve the medical needs of the elderly and disabled, we are gravely concerned for the future of Medicare. On behalf of our patients, we hope that the integrity of the program will not be further compromised in the coming Congressional budget deliberations.

During the past decade, Medicare has contributed more than any other domestic program to spending cuts. To continue these drastic reductions can only have a deleterious effect on the level and quality of care delivered to Medicare patients.

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[3] Our proposal to expand Medicaid is one of 16 proposals contained in our "Health Access America" plan to enhance and restructure the health care system to provide access to all Americans. See Appendix V.

Yet the Administration proposes cutting an additional $5.5 billion from Medicare. The proposed cuts are patently unreasonable.

The medical community appeals to Members of Congress and concerned citizens to consider the negative impact of continued spending cuts for Medicare patients.

American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology Head & Neck Surgery, Inc.
American Academy of Physical Medicine and Rehabilitation
American Medical Association
American Association of Neurological Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Nuclear Physicians
American College of Obstetricians and Gynecologists
American College of Rheumatology
American Congress of Rehabilitation Medicine
American Group Practice Association
American Psychiatric Association
American Society for Dermatologic Surgery
American Society of Addiction Medicine
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Clinical Pathologists
American Society of Internal Medicine
American Society of Plastic and Reconstructive Surgeons, Inc.
American Urological Association, Inc.
College of American Pathologists
Congress of Neurological Surgeons
Joint Council on Allergy and Imunology
Medical Group Management Association
Renal Physicians Association
Society of Nuclear Medicine

APPENDIX II.—PHYSICIAN REIMBURSEMENT RESTRAINTS UNDER MEDICARE

Since the inception of Medicare, Congress and the Department of Health and Human Services have taken actions that have resulted in reductions in Medicare reimbursement for services provided by physicians for Medicare beneficiaries. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for these services.

In 1969, prevailing charge levels were lowered from the 90th percentile to the 83rd percentile of customary charges. In 1970, prevailing charge levels were lowered to the 75th percentile of customary charges. For the second half of the 1971 fiscal year, physician's customary charges were based on the physician's median charge during the 1969 calendar year.

In August 1971, nationwide wage and price controls were imposed. While these controls were lifted seventeen months later for most of the economy, they still were retained for physicians for an additional fifteen months—until May 1974.

In 1972, Congress established further restraints through use of an economic index as a means to limit the rate of annual increase in prevailing charge levels. In 1976, the Medicare Economic Index (MEI) as used to set the prevailing charge limits using fiscal year 1973 charge screens that were based on physicians' charges during calendar year 1971.

Starting with the *Deficit Reduction Act of 1984* (DRA) further and substantial limits were imposed on physician reimbursement and charges for services provided Medicare beneficiaries. The DRA modified physician reimbursement in the following ways:

Two classes of physicians were created: "participating" physicians who agreed to accept all Medicare claims on an assigned basis and "non-participating" physicians who may continue to accept assignment on a claim-by-claim basis;

Medicare maximum reimbursement levels for physician services, customary and prevailing charge levels, were frozen for the period of June 30, 1984 to September 30, 1985 (if no freeze had been imposed by the DRA, the economic index would have allowed a 3.34% increase of prevailing charge levels on July 1, 1984);

The scheduled July 1, 1984 increase in fee profiles was eliminated, and the future annual update in fee profiles was delayed from July 1 to October 1, with the next increase set for October 1, 1985; and

Fees for services provided Medicare beneficiaries by "non-participating physicians" were frozen during this 15-month period. (Participating physicians were allowed to increase their fees for Medicare beneficiaries, but they are not allowed to collect this increased fee because of the agreement to accept assignment on all Medicare claims.)

The Emergency Extension Act again froze physician payment levels at the rates in effect on September 30, 1985 for 45-days. (This Act prevented a 3.15% increase from being applied to Medicare prevailing charge levels on October 1, 1985.) This Act also rolled back the actual charge levels allowed physicians who "participated" in FY85 but who had not agreed to "participate" in FY86. Further legislation extended the Extension Act, with fee and reimbursement levels again frozen through March 15, 1986.

The *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA) yet again extended the Medicare reimbursement freeze: (i) the freeze on Medicare reimbursement and charges for non-participating physicians was continued through December 31, 1986; and (ii) the freeze in the customary and prevailing charge levels for participating physicians was allowed to end May 1, 1986, with the prevailing charge increase for participating physicians set at only 4.15%.

The *Omnibus Budget Reconciliation Act of 1986* (OBRA-86) made substantial modifications in physician reimbursement and fee limits.

Reimbursement—Both participating and non-participating physicians were allowed an equal 3.2% update in Medicare prevailing charge levels beginning January 1, 1987. Beginning on January 1, 1987, prevailing charges for non-participating physicians were set at 96% of the prevailing charge levels allowed participating physicians.

Fees—The freeze on actual charges of non-participating physicians expired on December 31, 1986 and was replaced by Maximum Allowable Actual Charge (MAAC) limits. Each MAAC is determined by a complicated formula applicable to every charge of every individual physician. Physicians are subject to substantial penalties for violation of MAAC limits. MAAC limits are determined as follows:

If the physician's actual charge for any given service is at or above 115% of the prevailing charge (as determined from year to year), the actual charge for that service may be increased by no more than 1%. If the actual charge is less than 115% of the prevailing charge, that charge may be increased by the greater of 1% or as follows:

January 1, 1987—charge increases were limited to 1/4th of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1988—charge increases were limited to ⅓rd of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1989—charge increases are limited to ½ of the difference between the actual charge and 115% of the Medicare prevailing charge; and

January 1, 1990 and subsequent years—actual charges may be increased to 115% of the Medicare prevailing charge.

OBRA-86 reduced prevailing charge levels for cataract surgery by 10% in 1987 plus another 2% in 1988. A limit of 4 base units for anesthesia services related to cataract surgery also was set. Special limits on fees for these services also were imposed, with actual charges limited to ½ the amount by which the charge exceeds 125% of the new prevailing charge in 1987 and to 125% of the prevailing charge in 1988 and thereafter.

The *Omnibus Budget Reconciliation Act of 1987* (OBRA-87) made further substantial modifications in Medicare payment for physicians' services:

Three-Month Freeze—Prevailing and customary charge levels were maintained at the levels in effect during 1987 during the three-month period ending on March 31, 1988. Also during this three-month period, MAACs were kept at the amount determined for 1987. 1988 MAACs did not go into effect until April 1, 1988.

Sequestration—The Gramm-Rudman-Hollings sequestration reduced payments for physicians' services by 2.324% through March 1988.

Medicare Economic Index (MEI)—For services provided by participating physicians after March 31, 1988, the MEI increase was limited to 3.6% for primary care services and 1% for other physicians' services. Increases for the services of non-participating physicians were set at 0.5% less than the increase allowed participating physicians (3.1% and 0.5%). For physicians' services furnished in 1989, the increase for participating physicians is to be 3% for primary care services and 1% for other physicians' services. The increase in 1989 for non-participating physicians will be 0.5% less.

Reductions in Prevailing Charge Levels—The following physicians' services provided after March 31, 1988 were subjected to "reasonable charge" reductions: bronchoscopy (Codes 31622–31626), carpal tunnel repair (Code 64721), cataract surgery (Codes 66830–66985), coronary artery bypass surgery (Codes 33510–33528), knee arthroscopy (Codes 29880–29881), diagnostic and/or therapeutic dilation and curettage (Code 58120), knee arthroplasty (Codes 27446–27447), pacemaker implantation (Codes 33206–33208), total hip replacement (Codes 27130–27132), suprapubic prostatectomy (Code 55821), transuretheral resection of the prostate (Code 52601), and upper gastrointestinal endoscopy (Codes 43235–43239). The 1987 prevailing charge levels for these services initially were reduced by 2%. Further reductions of up to 15% were implemented according to a sliding scale formula for services between 85% and 150% of the national average.

Where a non-participating physician's allowed charge is reduced by the application of this provision (or for cataract procedures, or physician supervision of certified registered nurse-anesthetists), the physician may not charge the beneficiary more than 125% of the reduced allowed amount plus one-half of the amount by which the physician's MAAC for the service for the previous 12-month period exceeds the 125% level. In subsequent years, the maximum allowed charge will be set at 125% of the prevailing charge. here a physician "knowingly and willfully" imposes a charge in violation of this provision, the Secretary is authorized to apply sanctions (civil money penalties, assessments, and five-year barring) against the physician. These charge reductions will not apply to services furnished after the earlier of December 31, 1990 or one year after the Secretary reports to Congress on development of the RVS.

Payment for Physician Anesthesia Services—In determining the amount allowed for the medical direction of two or more nurse anesthetists (in which services are provided in whole or in part concurrently) for services provided after March 31, 1988 and prior to January 1, 1991, the number of base units recognized for the medical direction (other than for cataract surgery or an iridectomy) will be reduced from current levels by: 10% where the medical direction is of two nurse anesthetists concurrently; 25% where the medical direction is of three nurse anesthetists concurrently; and 40% where the medical direction is of four nurse anesthetists concurrently. here the anesthesia services are for concurrent cataract surgery or an iridectomy procedure provided after December 31, 1989 and before January 1, 1991, the number of base units that will be recognized for the medical direction will be reduced from current levels by 10%.

Fee Schedules for Radiologist Services—Medicare payments for radiologist services will be the lesser of 80% of the actual charge for the service or the amount provided under a fee schedule. "Radiologist services" are defined to include radiologic services performed by, or under the direction or supervision of, a physician who is certified or eligible to be certified by the American Board of Radiology, or a physician for whom radiologic services account for at least 50% of his or her Medicare billings.

Radiology Charge Limitations—Where radiologist services are provided by non-participating physicians or suppliers after 1988 and where payment: is made pursuant to the fee schedule, the maximum amount that may be billed will be subject to a "limiting charge." The limiting charge will apply as follows: in 1989—125% of the amount specified in the fee schedule; in 1990—120% of the amount specified in the fee schedule; and after 1990—115% of the amount

specified in the fee schedule. are a charge is "knowingly and willfully" imposed above the limiting charge, sanctions may be applied.

Limits on Payment for Ophthalmic Ultrasound—Effective for services provided after March 31, 1988, the prevailing charge level for A-mode ophthalmic ultrasound procedures may not exceed 5% of the prevailing charge level established for extracapsular cataract removal with lens implantation. Limits on actual charges for this service also apply.

Customary Charges for Services of New Physicians—For physicians who do not have adequate actual charge data, customary" charges are to be set at 80% of the prevailing charge for the service in the area. (Previously, these charges were set at the 50th percentile of customary charges in the area, an amount usually above prevailing charge levels.) This limit is not applicable for primary care services or for services provided in designated rural areas.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) made the following significant modifications to physician payment under Medicare:

Physician Payment Reform—Beginning in 1992, payment for physicians' services, for which payment presently is on a "reasonable charge" basis or in accordance with the radiology fee schedule, will be based on the lesser of the actual charge for the service or the amount determined under the fee schedule for a particular year.

Medicare Volume Performance Standard (MVPS) Rates of Increase—By April 15 of each year (beginning with 1990) the Secretary will present to Congress a recommendation on MVPS rates of increase for all physicians' services and for each category of such services for the upcoming fiscal year.

Extension of Sequestration—The 2% sequestration reduction in payment will be maintained and extended to March 31, 1990. After this date, a 1.3% partial sequester will continue throughout the fiscal year. (The Part A sequester of 2% is continued through December 31, 1989, with a 1.3% partial sequester continuing throughout the fiscal year.)

Delay in Update and Application of the Medicare Economic Index

- *Updates*—Part B payment increases or adjustments scheduled to occur as of January 1, 1990 (i.e., adjustments to customary or prevailing charges, fee schedule amounts, MAACS, and other limits on actual charges) shall be postponed until April 1, 1990. In lieu of any increase or adjustment from January 1, 1990 to March 31, 1990, the amount of payment and limits for all Part B covered services (other than ambulance and clinical diagnostic laboratory services) will be the same as those in effect on December 31, 1989.
- *Medicare Economic Index (MEI) Percentage Increase*—The percentage increase in the MEI for services furnished in 1990 (after March 31, 1990) will be:
  - the full percentage increase (5.3%) as would otherwise be determined for primary care services (office medical services, certain eye examinations, emergency department services, home medical services, skilled nursing, intermediate care and long-term care medical services, and nursing home, board home, domiciliary or custodial care medical services);
  - 2% for other services (not including primary care services); and
  - 0% for radiology, anesthesia and "overvalued" services.

Reduction in Payments for Overvalued Services—Medicare payment for certain physicians' services provided from April 1, 1990 through December 31, 1990 and identified as "overvalued" will be reduced.

Reduction in Payments for Radiology Services

- *Fee Schedules for Radiologists' Services*—The conversion factors used to compute fee schedules for radiologists' services (excluding portable x-ray services) furnished in 1990 (after March 31, 1990) shall be 96% of the factors applied as of December 31, 1989.

Customary Charge Levels for New Physicians—In determining customary charge levels for physicians' services furnished in 1990 and beyond (on and after April 1, 1990) by "new" physicians—physicians for whom adequate actual charge data are not yet available—the Secretary shall set customary charge levels at the start of the second calendar year in the practice at no higher than 85% of the prevailing charge levels.

Payment Limits for Services Furnished by More Than One Specialty—The Secretary shall designate certain surgical, radiological and diagnostic physicians' services that: (1) account for a high volume of Part B expenditures; and (2) have varying prevailing charges, depending upon the specialty of the physician furnishing the service. For any such designated service performed after March 31, 1990 the prevailing charge may not exceed the prevailing charge or fee schedule amount for the specialty that furnishes the service most frequently nationally. Where a non-participating physician provides one of these services after March 31, 1990, special MAACs will apply. (The charge may not exceed 125% of the reduced allowed amount plus one-half of the amount by which the physician's MAAC for the service for the previous year exceeds the 125% level in the first year, and 125% of the reduced amount in subsequent years.)

Balance Billing Limitations—For 1991 the limiting charge shall be the lesser of 125% of the prevailing charge levels or the MAAC amount. In 1992, the limit shall be the lesser of the MAAC amount or 120% of the fee schedule amount for non-participating physicians. For years 1993 and after, the limit shall be 115% of the non-participating physicians' payment schedule. If a non-participating physician knowingly and willfully bills on a repeated basis an actual charge in excess of the limiting charge amount, the Secretary may apply sanctions against the physician.

Effective April 1, 1990, payment for physicians' services provided beneficiaries who are eligible for medical assistance, including qualified Medicare beneficiaries, will only be made on an assigned basis.

Physician Submission of Claims—Physicians and suppliers shall submit claim forms (whether or not the claim is assigned) for care provided to Medicare patients on or after September 1, 1990. Claims must be submitted within one year and no charge may be imposed for completing and submitting such forms. If a physician fails to submit an assigned claim as required, the Secretary shall reduce the amount otherwise paid by 10%. If a nonassigned claim is submitted sanctions would apply.

APPENDIX III.—ACTUAL MEDICARE CASH DISBURSEMENTS, FISCAL YEARS 1981–1989

	1986	1987	1988	1989
Dollar outlays (millions):				
Part A benefit payments	$49,018	$49,967	$52,022	$57,433
Inpatient hospital	46,055	46,840	48,787	52,384
Skilled nursing facility	582	623	720	2,193
Home health	2,195	2,287	2,261	2,534
Hospice	35	63	90	120
PRO activity	151	154	164	202
Part B benefit payments	25,169	29,937	33,682	36,867
Physician	18,553	21,926	24,243	26,150
Outpatient [1]	4,922	5,780	6,456	7,329
Home health	47	48	56	48
Group practice plans	953	1,336	1,952	2,218
Independent labs	694	847	975	1,122
Total benefit payments	74,187	79,904	85,704	94,300
Administrative expenses	1,716	1,736	1,972	2,154
Total outlays	75,903	81,640	87,676	96,454
Percent chance from previous year:				
Part A benefit payments		1.9	4.1	10.4
Inpatient hospital		1.7	4.2	7.4
Skilled nursing facility		7.0	15.6	204.6
Home health		4.2	−1.1	12.1
Hospice		80.0	42.9	33.3
Part B benefit payments		18.9	12.5	9.5
Physician		18.2	10.6	7.9
Outpatient [1]		17.4	11.7	13.5
Home health		2.1	16.7	−14.3
Group practice plans		40.2	46.1	13.6
Independent labs		22.0	15.1	15.1
Total benefit payments		7.9	7.3	10.0
Administrative expenses		1.2	13.6	9.2

APPENDIX III.—ACTUAL MEDICARE CASH DISBURSEMENTS, FISCAL YEARS 1981–1989—Continued

	1986	1987	1988	1989
Total outlays		7.6	7.4	10.0

Source: Tables provided by HCFA Office of the Actuary and Office of Budget Administration.
Prepared by the AMA Center for Health Policy Research.
[1] 86% of outpatient services are provided in hospital settings.
2/22/90

APPENDIX IV.—AMA ANALYSIS OF THE ADMINISTRATION'S PROPOSED FISCAL YEAR 1991 BUDGET FOR HEALTH PROGRAMS

The Bush Administration's Federal budget for fiscal year (FY) 1991 projects a deficit of $63.1 billion, based on revenues of $1.170 trillion and outlays (spending) of $1.233 trillion. The projected deficit for FY91 is below the $64 billion deficit ceiling set by the Gramm-Rudman-Hollings law.

The FY91 budget requests $464.2 billion in outlays for HHS. This amount represents an increase in total outlays of almost $27.4 billion (6.3%) compared to current estimates for FY90. The largest component of the HHS budget—approximately 60%—is for Social Security outlays of $280.3 billion (an increase of about $17.6 billion [6.7%] over estimated FY90 outlays).

The budget again targets the Medicare program for major cuts and proposes nearly $5.5 billion in Medicare "savings." Including these proposed savings, the projected outlays for the Medicare program are $110.5 billion (an increase of $4.9 billion [4.6%] over the estimated FY90 outlays). The Federal share of Medicaid outlays is estimated at $44.9 billion (an increase of about $4.7 billion [11.7%] over FY90).

The budget request for the Public Health Service is $15.4 billion, an increase of $1.3 billion (9.2%) over the estimated FY90 appropriation.

MEDICARE

During the 1980s, the Medicare program has been subjected to numerous, and often arbitrary spending cuts. The Association continues to be concerned that such cuts threaten access to and quality of care for Medicare beneficiaries. The Association opposes any additional arbitrary reductions in either Part A or Part B of Medicare. However, the Association continues to support certain revenue-enhancing proposals, including raising the Part B premium to at least 35% of program costs and requiring all state and local government employees to pay Hospital Insurance taxes.

A. Part A Provisions

The FY91 budget contains proposals to reduce Part A outlays by nearly $3.4 billion in 1991, and $22.3 billion over five years.

1. *Increase Payments to Medicare's Risk-Contracting Health Maintenance Organizations (HMOs) (Costs of $100 million in Part A and $80 million in Part B in 1991)*

The budget proposes to increase payments to Medicare's risk-contracting HMOs from 95% to 100% of the estimated per capita cost to Medicare for beneficiaries served by fee-for-service providers (the adjusted average per capital cost—AAPCC). A portion of the increase would be used to reduce beneficiaries' premiums (directly or through rebates), and the remainder would go to the HMO for the purpose of expanding benefits or reducing premiums.

DISCUSSION: Under current law, Medicare pays risk-contracting HMOs at a level equal to 95% of the AAPCC. The proposed increase would be used to increase HMO revenue and reduce beneficiary costs and increase the attractiveness and availability of managed care options. The Association notes that a recent GAO study concluded that raising the payment rate for at-risk HMOs would increase program costs without any significant benefit. The study, ordered by Rep. Stark (D–Ca), found that factors other than payment rates (such as low Medicare enrollment) are driving HMOs out of the risk contract program. The Association also questions the appropriateness of further government action to encourage one method of health care coverage over other coverage mechanisms.

AMA POSITION: The AMA recommends *opposition* to this proposal.

2. *Reduction in Capital Payments (Savings of $1.530 billion in 1991)*

Under current law for the period January 1—September 30, 1990, capital payments to certain hospitals are reduced by 15%. The budget proposes to continue this

reduction for rural hospitals, and to increase the reduction to 25% for urban hospitals.

DISCUSSION: The Association is concerned that inappropriate reductions of capital cost reimbursement could have a severe negative impact on the ability of patients to obtain needed medical and health care services. The Association does not believe further capital cost cuts are appropriate until the effect of recently imposed cuts can be assessed. The Association further believes that any budget proposal regarding hospital capital cost reimbursement must be carefully assessed to ensure that institutions can provide needed patient services, and that adequate transition time is provided to meet existing capital cost obligations.

AMA POSITION: The Association recommends opposition to further hospital capital costs reductions.

3. *Prospective Pricing System (PPS) Update of 4.1%* (Savings of $640 million in 1991)

The budget proposes a PPS update of 4.1% (market basket minus 1.5%).

DISCUSSION: The AMA supported the concept in the original PPS legislation of allowing an annual PPS update of market basket plus 1%, with the 1% being for new technology. Although the Association is cognizant of the need for savings from all sectors of the budget, the market basket represents cost increases of goods and services that hospitals must buy in an uncontrolled market. The Association cannot support an adjustment below the market basket based on the current patient care, economic and hospital climate.

AMA POSITION: The AMA recommends *support for a full market basket increase in the PPS adjustment.*

4. *Reduction in Indirect Medical Education (IME) Payments* (Savings of $1.03 billion in 1991)

The budget proposes decreasing IME payments by lowering a factor in the payment formula from 7.7% to 4.05%.

DISCUSSION: The Association notes the recent history of cuts in the IME payments, and has serious concerns about the future effect on health care if there are further reductions in these payments. Expenditures on graduate training should be viewed as investments in the future health care of America. The Association believes that there should be no further reductions in this payment amount without a thorough analysis, based on reliable statistical data, on whether such cuts would be deleterious to teaching hospitals and their patients.

AMA POSITION: The Association recommends *opposition to IME payment reduction below 7.7%.*

5. *Reform Graduate Medical Education (GME) Payments* (Savings of $170 million in Part A and $35 million in Part B in 1991)

The budget proposes to establish a "per resident" GME payment amount derived from the national average of FY 1987 residents' salaries updated by the CPI. Primary care residents would be weighted at 180% of the per resident amount, non-primary care residents in their initial residency would be weighted at 140%, and non-primary care residents beyond their initial residency period would be weighted at 100%.

DISCUSSION: Currently, Medicare payments to hospitals for their medical residents vary due to historical patterns in hospital accounting. The Association supports full funding for the direct costs of medical education through salaries and stipends, etc. In addition, the Association opposes differential GME payments based upon specialty.

AMA POSITION: The Association recommends *opposition* to the proposed funding reduction.

6. *Can Intern- and Resident-to-Bed Ratios (IRB) at FY89 Levels* (Savings of $10 million in 1991)

The budget proposes to cap IRB ratios at FY89 levels.

DISCUSSION: The proposed cap is intended to prevent hospitals from closing beds solely to raise their IRS ratios, thereby reaping "windfall" payments. Although some hospitals might close beds solely to increase their IRS ratios, the Association believes this is unlikely. Furthermore, a universal IRS cap at FY89 levels would arbitrarily disregard legitimate IRB changes and could act as an arbitrary disincentive to hospital merger and growth.

AMA POSITION: The Association recommends *opposition* to this provision.

B. PART B PROVISIONS

The FY91 budget contains proposals to reduce Part B outlays by $2.2 billion in FY91, and $23.9 billion projected over five years.

1. *Part B Premium*

The budget proposes to set a floor on the rate of increase for the Part B premium each year, beginning in calendar year 1991, at the level that would be necessary to finance 25% of the program.

DISCUSSION: The Association notes that the premium originally was designed to fund 50% of Part B expenses, and believes that an increase in the Part B premium to fund at least 35% of program costs is more appropriate.

AMA POSITION: The Association recommends *support for a premium floor of at least 35% of program costs.*

2. *Updates*

a. *Medicare Economic Index (MEI) Update Only for Primary Care Services* (Savings of $450 million in FY91)

The budget proposes to provide full customary and prevailing charge level updates for 1991 only for primary care services, with customary and prevailing charge updates frozen for non-primary care services. The budget also proposes to implement a 1991 consolidation of customary and prevailing charge screens, currently scheduled to be used in 1992 as the basis for the transition to the resource-based fee schedule.

b. *Reduce Payments for Certain Overvalued Procedures* (Savings of $110 million in FY91)

The budget proposes to reduce payments for overvalued procedures by two-thirds of the remaining amounts by which they are overvalued, up to a maximum reduction of 25 percent. (OBRA-89 reduced payments for selected overvalued procedures by one-third of the amount by which they were determined to be overvalued compared to an estimated resource-based fee schedule, up to a maximum reduction of 15 percent.)

c. *Reduce Payments for Overvalued Localities* (Savings of $50 million in FY91)

The budget proposes to reduce payments for certain procedures in localities where payments are overvalued relative to the national average, once the average has been adjusted to account for differences in practice costs among areas. The maximum reduction for any procedure in a locality in 1991 would be 25 percent.

DISCUSSION: These proposals present issues where there is a long history of arbitrary payment reductions. Indeed, this history of payment reduction was one of the reasons for Congressional support for the implementation of a Medicare payment system based on a resource-based relative value scale (RBRVS). Noting AMA support for an RBRVS payment mechanism, as further refined and developed, the Association believes that the process is in place to develop appropriate reimbursement for these services. Additional cuts, especially with the RBRVS scheduled for implementation in the near future, would be arbitrary and short-sighted. Such cuts would also increase dislocations that the transition, adopted by the Congress, is designed to limit and thus ameliorate concerns about access to services.

AMA POSITION: The Association recommends *opposition* to these three proposals.

3. *Reduce Radiology and Anesthesia Fees* (Savings of $230 million in FY91)

The 1991 budget proposes to reduce radiology and anesthesia fees by the amount that current fees exceed an estimated resource-based fee schedule, with a 25% maximum reduction in any locality in 1991. The budget also proposes to pay the same amount for anesthesia services whether an anesthesiologist or a certified registered nurse anesthetist (CRNA) performs the service. Under this proposal, Medicare would pay the anesthesiologist for medical direction an amount equal to the difference between the payment the anesthesiologist would have received for personally performing the service and the CRNA payment. Medicare payment for CRNAs would not be reduced.

DISCUSSION: The Association believes that payment for these services would best be determined through the use of a resource-based relative value fee schedule. The Association also notes the significant difference in anesthesia care provided by an anesthesiologist and a CRNA, and strongly opposes basing payment for this care at a single rate.

AMA POSITION: The Association recommends opposition to this proposal.

4. *Reform Payments for Assistants-at-Surgery and Surgical Global Fees* (Savings of $170 million in FY91)

The budget proposes to pay the same amount for surgery regardless of whether the primary surgeon uses a surgical assistant to whom Medicare would make a separate payment. The payment to the primary physician would be reduced by the amount of payment to the assistant surgeon. The budget also proposes to reduce surgical payments by either a procedure-specific amount (where data are available) or 2% across-the-board.

DISCUSSION: The Association notes that while some abuses may occur in the use of surgical assistants the proposal would jeopardize the quality of care that a Medicare beneficiary may receive. This is especially important where a procedure requires more than one physician, including team procedures and operations when multiple procedures are being performed. Furthermore, the Association believes that a reduction in surgical global fees at this time is inconsistent with the transition to the RBRVS based payment schedule.

AMA POSITION: The Association recommends that this proposal *be strongly opposed.*

5. *Phase-in Increase for New Physicians* (Savings of $50 million in FY91)

OBRA '87 set limited customary charge levels for new physicians at 80% of prevailing levels, and OBRA '89 continued to phase-in customary charge level increases by limiting Payments to second year physicians to 85% of the prevailing charge. The budget proposes to continue to phase in customary charge level payment limits for new physicians as follows; 90% for third year physicians, 95% for fourth year physicians, and 100% of the fee schedule for fifth year physicians. The budget also proposes to extend this policy to other practitioners reimbursed on a fee-for-service basis.

DISCUSSION: The Association continues to believe that fee schedules should not differentiate for years in practice.

AMA POSITION: The Association recommends *opposition* to this proposal.

6. *Technical Components of Diagnostic and Radiology Tests* (Savings of $60 million in FY91)

The budget proposes to apply a cap at 100% of the national median for the technical component of radiology services and diagnostic tests, similar to the cap on carrier-specific fee schedules for clinical laboratory diagnostic tests.

DISCUSSION: The Association believes that the use of caps and median national charges to establish payment levels is inappropriate as no consideration is given to the actual cost of providing the services in various localities.

AMA POSITION: The Association recommends *opposition* to this proposal.

7. *Physician Assistant (PA) Offset* (Savings of $5 million in FY91)

The budget proposes to eliminate duplicate payments for PA services furnished in hospitals by offsetting them from the hospitals' Medicare payments. An exception would be made for inhospital PA services furnished in manpower shortage areas.

DISCUSSION: While the Association previously opposed direct payment for PA services, it notes that duplicate payment for the same services should be avoided. The Association is opposed to double payments, even for hospitals located in manpower shortage areas.

AMA POSITION: The Association recommends continued opposition to direct payment for PA services, but as long as PA services are directly reimbursed to hospitals, the Association recommends *support* of this proposal to end duplicate payment for all hospitals.

8. *Voluntary Hospital Physician Participation* (no cost)

The budget proposes to allow hospitals the option of voluntarily becoming "Medicare Participating Physician Medical Staff Hospitals." These hospitals would contract with Medicare to guarantee that assignment would be accepted for the following physician services: emergency, radiology, anesthesia and pathology services and consultations.

DISCUSSION: The Medicare participating physician program would be more offensive under this proposal than it is currently in that *all* physicians in the respective specialties would be required to abide by the decision of the majority to "par-

ticipate." The Association reaffirms its opposition to the Medicare participating physician program.

AMA POSITION: The Association recommends *vigorous opposition* to this proposal.

9. *Reduce Hospital Outpatient Payments* (Savings of $670 million in 1991)

The budget proposes a 10% across-the-board reduction in Medicare payments for certain hospital outpatient services, beginning in 1991. In addition, the budget proposes that capital payments for outpatient departments be paid at 85% of costs for rural hospitals and 75% of costs for urban hospitals. No reduction is proposed for sole community hospitals.

DISCUSSION: The Association is concerned that the arbitrary reduction would inadvertently have an adverse effect on outpatient services in various settings. The Association is also concerned that inappropriate implementation of changes in capital cost reimbursement could have a severe negative impact on the ability of patients to receive needed medical services. Any proposal affecting outpatient services, one of the fastest growing components of Medicare, must be closely monitored to assure that institutions can properly provide needed services for patients, and that any such proposal provides for an adequate transition to allow institutions to meet already committed capital cost obligations.

AMA POSITION: The Association recommends *opposition* to this proposal.

10. *Durable Medical Equipment (DME) Proposals* (Savings of $250 million in 1991)

- *National Cap on Fee Schedules*—For all fee schedules for DME, prosthetics and orthotics, the budget proposes to limit Medicare payment to the median of the fee schedule amount for each item, with a fee update only for those items below the limit.
- *Modify Fee Schedule for DME Rental Items*—The budget proposes to change the fee schedule for this rental category from average submitted charges to average reasonable charge to make it consistent with other DME categories. In addition, the budget proposes to limit total monthly payments to 120% of the recognized purchase price (reduced from 150%).
- *Reduce oxygen payments by 5 percent*—OBRA '87 established a fee schedule for oxygen based on 95% of the local average amount reimbursed by Medicare in 1986. The budget proposes to reduce the reimbursement amount by 5%.
- *Fee Schedule for Enteral Products and Supplies*—The budget proposes to establish a fee schedule for enteral nutrients and supplies based upon wholesale and retail price information.

DISCUSSION: The Association supports payment levels for these DME services that are adequate to assure patient access to medically necessary DME. However, the Association is concerned that there are abuses in the use of DME and recommends further analysis to assure that only medically necessary DME is covered by Medicare.

AMA POSITION: The Association recommends continued monitoring of access to and payment for medically necessary DME.

11. *Competitive Bidding*

The budget proposes to give "serious consideration" to conducting competitive bidding demonstrations to determine payment levels for clinical laboratory services.

DISCUSSION: The Association reaffirms its policy of opposing the use of the competitive bidding process to establish payment for physician services.

AMA POSITION: The Association recommends *opposition to* this proposal.

12. *Clinical Laboratory Services* (Savings of $60 million in FY91)

The budget proposes to reduce the Medicare payment limit to 90% of the median fee schedule amounts for non-profile tests and 80% of the median for profile and standardized test packages, with fee updates only for fees below the limit.

DISCUSSION: The Association is concerned that the use of the national "median" to establish payment levels in areas of high labor and other costs would be inequitable, as the payment level would automatically be adjusted downward with no consideration as to the actual cost of providing the tests.

AMA POSITION: The Association recommends *opposition* to this proposal.

13. *Provide Prior Authorization Authority to Carriers* (Savings of $64 million in 1991)

The budget proposes to extend to Medicare carriers the authority to require prior authorization for medical services and/or equipment.

DISCUSSION: This proposal would result in duplication of effort in that the Peer Review Organization now carries out prior authorization. Granting this authority to the carrier, which in most circumstances lacks medical expertise, would result in increased administrative burdens, duplicative efforts, and an additional level of review by untrained personnel.

AMA POSITION: The Association recommends opposition to this proposal.

14. *Catastrophic Health Insurance (CHI)*

The budget proposes that the monthly CHI flat premium revenues collected in 1989 and currently in the SMI trust fund be transferred to the HI trust fund to offset the costs of CHI hospital and SNF benefits paid from that trust fund during 1989.

DISCUSSION: The Association believes that this proposal, which transfers funds from one account to another to pay for services provided under the now repealed Medicare Catastrophic Coverage Act, should be supported.

AMA POSITION: The Association recommends *support* of this proposal.

APPENDIX V.—HEALTH ACCESS AMERICA

THE SIXTEEN-POINT PROPOSAL

The AMA proposal is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicare program to assure proper health care for all. It is summarized as follows:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level.
2. Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage.
3. Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable.
4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program to assure the aging population of continued access to quality health care. The program would include catastrophic benefits and be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens.
5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.
6. Enact professional liability reform essential to reducing inordinate costs attributable to liability insurance and defensive medicine, thus reducing health care costs.
7. Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided, lowering costs and maintaining quality of care.
8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.
9. Develop proposals which encourage cost-conscious decisions by patients.
10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance.
11. Urge expanded Federal support for medical education, research and the National Institutes of Health, to continue progress toward medical breakthroughs which historically have resulted in many lifesaving and cost-effective discoveries.
12. Encourage health promotion by both physicians and patients to promote healthier lifestyles and disease prevention.
13. Amend ERISA or the Federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-regulated health insurance policies, providing fair competition.
14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.
15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike.

16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

APPENDIX VI

February 20, 1990.

GAIL WILENSKY, PH.D., *Administrator,*
Health Care Financing Administration,
200 Independence Avenue, SW,
Washington, DC

Dear Dr. Wilensky: We are taking the extraordinary step of reacting formally to an unpublished draft of a Notice of Proposed Rulemaking (NPRM) on the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) because of our shared concern that the Department may adopt an inappropriate and unduly rigid interpretation of the requirements of the legislation. Particularly as the NPRM pertains to regulation of physicians' office-based testing, it would unnecessarily jeopardize patients' access to needed services. We understand that this draft may have been changed and that the regulations eventually will be proposed for public comment, but in view of the fundamental importance of these regulations to patients, laboratories, physicians, distributors, and manufacturers of—laboratory testing systems, we wish to make you aware of our concerns and recommendations before the proposed regulations reach you for approval.

We believe that CLIA-88 provides sufficient flexibility for the development of balanced, reasonable regulations. To achieve that goal, we would like to meet with you as soon as possible to provide our assistance as you formulate direction for your agency.

CLIA-88 expands Federal regulatory oversight from approximately 12,000 traditional sites (hospital and interstate labs) to all physician office laboratories and other testing facilities. Estimates range as high as 300,000 sites to be affected by these regulations. This expansion of regulatory oversight will put an enormous burden on the Department and challenge the ability of the agency to fairly and effectively regulate this many laboratories. Implementation of the law will also place a substantial burden on the medical profession and laboratory community. All parties—regulators, regulated and the patients we serve—share a common interest in implementing the law in the most cost-effective and practical fashion.

The NPRM working draft is totally unresponsive to CLIA-88 goals and would lead to results diametrically opposite from those intended by Congress. Indeed, the draft NPRM would create an oversight system that would require by far the largest share of resources to be directed to identifying and regulating the simplest diagnostic testing. If implemented as written, the regulation would render physicians incapable of providing access to the clinical benefits of timely, convenient testing for patients in their offices.

The draft regulation would place most physicians and other laboratories performing the simplest office-based testing, such as routine clinical chemistry, in the same category as the largest hospital and interstate labs offering the most complex testing. For example, the solo practitioner doing the occasional finger-stick hemoglobin would be faced with the same requirements for CLIA compliance as the laboratories at the Johns Hopkins Medical Center: the same standards for quality assurance, quality control, proficiency testing, inspection, patient test management, and personnel.

In order to avoid this kind of result, we offer as guidance a set of principles that form the basis for accreditation of physicians office laboratories conducted by the Commission on Office Laboratory Assessment (COLA).[1] COLA is a voluntary education and accreditation program that reflects the efforts of specialists in laboratory medicine and primary care physicians to assure that office-based testing produces high quality results. In particular, the COLA program provides a valuable model for addressing the types of testing commonly performed in physicians' offices. We look forward to discussing the relevance of the COLA program to your regulatory activities.

We believe that the fees which would be necessary to maintain regulatory oversight based on the kind of framework that a COLA model would entail would be far

[1] COLA is sponsored by the American Academy of Family Physicians, the American Society of Internal Medicine, the College of American Pathologists, and the American Medical Association.

more reasonable than the biennial fees beginning at two thousand dollars ($2000) per site which are reportedly under consideration by the agency.

Furthermore, a workable approach to regulation of labs such as physician office labs, given the great variety of technologies commonly found in these settings, must take into account the technology actually employed rather than the substance being measured.

We urge you to refrain from publishing any NPRM until all essential elements for implementing CLIA-88 are described in the proposal. For example, the draft NPRM fails to address key issues such as the criteria for private sector (deemed status) accrediting bodies and requirements for those organizations that wish to be recognized as acceptable proficiency testing programs. The quality of public comment should be much better if commenters understand how the entire regulatory system will work rather than comment on individual, disjunctive portions of the regulations.

Finally, we believe that this regulatory program clearly constitutes a major rule under Executive Order 12291—given that estimates of inspection fees alone now run to almost $200 million—warranting careful analysis of the costs and benefits of every aspect of the proposed implementing regulations.

Please understand we are not challenging the requirements of CLIA-88, nor do we seek an inappropriate delay in publication of the regulations. Many of us worked very hard assisting Congress in drafting CLIA-88 to ensure that quality control provisions for physician office laboratories were enacted. We would like to work with you to see the law implemented in a responsible fashion which achieves the intent of Congress in a practical and effective way.

Sincerely,

AMERICAN ACADEMY OF DERMATOLOGY
AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY
AMERICAN ACADEMY OF FAMILY PHYSICIANS
AMERICAN ACADEMY OF OPINALMOLOGY
AMERICAN ACADEMY OF PHYSICAL MEDICINE
AMERICAN ASSOCIATION OF CLINICAL UROLOGISTS, INC.
AMERICAN COLLEGE OF PHYSICIANS
AMERICAN COLLEGE OF RHEUMATOLOGY
AMERICAN MEDICAL ASSOCIATION
AMERICAN SOCIETY FOR DERMATOLOGIC SURGERY
AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
AMERICAN SOCIETY OF HEMATOLOGY
AMERICAN SOCIETY OF INTERNAL MEDICINE
AMERICAN UROLOGICAL ASSOCIATION, INC.
HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION
HEALTH INDUSTRY MANUFACTURERS ASSOCIATION
JOINT COUNCIL ON ALLERGY AND IMMUNNOLOGY
RENAL PHYSICIANS ASSOCIATION

Attachments.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION TO THE PHYSICIAN PAYMENT REVIEW COMMISSION

[Presented by James S. Todd, M.D., January 18, 1990]

Re: PPRC 1990 Report to Congress

Mr. Chairman and Members of the Commission: My name is James S. Todd, M.D. I am the Senior Deputy Executive Vice President of the American Medical Association. The AMA appreciates this opportunity to appear before you today. Today's hearing will cover issues to be included in your 1990 report to Congress. I want to emphasize how much the AMA values the continuing opportunity to meet with the Commission to further our common purpose in improving Medicare physician payment policy. We can be justifiably proud that the physician payment reform legislation recently adopted by the Congress reflected so many policy recommendations developed by our respective organizations in recent years.

In our testimony today, we will present our views on the key issues to be considered in your 1990 Report to the Congress. On many issues we appear in substantial agreement. These include completion of an RBRVS-based payment schedule, improvement of clinical care, and Medicaid expansion. For some specific issues, however, such as refinement of the RBRVS, practice costs, and geographic cost multipli-

ers, we have suggestions on detailed policy implementation. Finally, in a few major instances, most notably further balance billing limits and MVPS implementation, we continue to hold strongly divergent views.

MEDICARE FEE SCHEDULE

Refining the Scale of Relative Work

Evaluation and Management Services

We are pleased with the substantial progress that we have made in this endeavor. It provides a concrete, workable model for future collaborative efforts between the AMA and the PPRC we look forward to continued progress.

Surgical Global Services

We have been supportive of, and impressed by, your efforts to define a standard global payment policy for surgical services under a national Medicare payment schedule. We do have a few concerns, however, about your plan to assign relative values to those global services. First, most observers of payment reform have assumed that the primary data needed to fully estimate global fees, *and unavailable from the Harvard RBRVS study,* were for care provided prior to and after hospitalization. In contrast, the PPRC's effort will assign relative values to the *entire global fee,* only retaining original Harvard RBRVS estimates for the intra-operative period (and scrub time). Like the PPRC, we have identified problems with the Harvard estimates of pre- and post-work. Nevertheless, we do not have sufficient information to judge whether the method proposed by the Commission to estimate within-hospital pre- and post-time work is clearly superior to estimates that will be available upon the completion of Phase II of the Harvard study.

It is clear that, with your proposed process, a substantial fraction of the relative work values for surgical services will be estimated through a model and method substantially different in many respects from Harvard's. These departures are especially notable in data collection and in the apparently more limited definition of within-hospital pre- and post-time as being comprised of *visits* rather than *all distinct in-hospital physician services.* These new methods may alter the eventual impacts on various specialties.

We are especially interested to learn much more about how you will validate the considerable data provided by surgical specialty societies. We hope that their work is not overshadowed by validation data that may not be fully representative of physician practices. For example, the PPRC may utilize data from only those Medicare carriers that have chosen not to include office visits in global fees. Such data, however, may not be representative of actual physician practices. Similarly, the fact that data may be available from some HMOs and multispecialty groups does not make them universally applicable. Perhaps of greatest concern is the questionable presumption that a panel of "financially disinterested physicians," whoever they might be, is a valid method to judge data on the practices of physicians that might be very different from their own. We hope that, in assigning these relative values, like Harvard, you will follow an open process of review, constructive criticism, and refinement.

Review and Refinement of the Scale of Relative Work

You have outlined a process that should meet the key goals associated with producing relative work estimates appropriate for use in a Medicare payment system. We appreciate your inclusion of the AMA in this effort. We will comment briefly on the process that you have outlined.

The first step, in which relative values for surveyed services are refined, is critical. We do believe that your proposed requirement that data to support a specialty's position must be either available or "generated easily" in order to correct an RVS estimate is overly stringent. It should be sufficient for a specialty to identify the reasonable likelihood of a problem. The burden should then be on the PPRC or HCFA to demonstrate that the methods used have adequately addressed the problem in question.

We are also concerned about an inherent bias in the process to raise relative values because suggestions of "inappropriately high" relative values are less likely to emerge in this review. Given budget constraints, such a bias will lead to offsetting payment reductions in other services. The planned advisory panel is clearly the PPRC's answer to this problem, and we have several suggestions to enhance such a panel's usefulness. First, we suggest that the panel will be most productive and have the greatest standing if its members are both nominated by, and at some level formally representative of, the specialty societies that represent the specialty inter-

ests of physicians. Next, we believe that a substantial number of panelists should be nominated directly by the AMA to inject the broad physician perspective that will facilitate compromise. Finally, we suggest that this panel, as in the current PPRC/AMA Evaluation and Management (EM) coding process, be jointly convened by the AMA and the PPRC.

Step two, refinement of cross-specialty links and extrapolations, is also necessary for the completion of a final RBRVS. Again, we appreciate your inclusion of the AMA in this process. The third step, refinement of relative values by each specialty, is a logical progression from the preceding activities and we also have some suggestions. First, we propose that this step be a joint effort of the PPRC and the AMA in order to provide an overall physician viewpoint. As with the ongoing EM process, the AMA would be responsible, with the PPRC, for convening these specialty panels and for providing joint oversight. We also urge you to clarify that the primary purpose of this stage is to review *extrapolated* values. Using a consensus process to alter the refined relationships between *surveyed services* would tend to undermine the fundamental basis of the RBRVS.

Finally, we suggest a caution regarding the proposed constraint, during this review, of "budget neutrality" within a specialty/category of service combination. Although such a constraint will obviously ease the work of these panels, it may unfairly penalize physicians for continued inadequacies in charge databases used for extrapolation. For example, the "budget" for a specialty may itself be biased downward by charge data that, however refined, do not correlate with relative work.

The fourth step, final interspecialty refinements, is really too preliminary for useful comment at this time. We would, however, suggest that considerable thought is needed before a value for a non-EM service provided by multiple specialties is simply assigned a mean relative value. If resource cost data reveal meaningful inter-specialty differences in relative work, and coding revisions are not warranted, it may be necessary for the Commission to rethink its firm position against specialty differentials.

Payment for Radiology, Anesthesiology and Pathology Services

The physician payment reform legislation requires that the current Medicare radiology RVS and anesthesiology Relative Value Guide (RVG) be integrated into the overall Medicare RVS. Unfortunately, it is not clear on how such integration is to be achieved. We urge the PPRC to work to ensure that these RVSs are fully linked to the overall RBRVS through valid cross-specialty relationships developed by the Harvard research team. In addition, we believe that any remaining concerns regarding the nuclear medicine relative values in the radiology RVS must be resolved before this RVS can be considered applicable to all radiology services as defined in the legislation. Finally, our interpretation of the legislation is that the separate pathology fee schedule is to be superseded by the full RBRVS payment schedule. We hope that the PPRC and HCFA will give appropriate weight to the RBRVS restudy of pathology services currently being conducted at Harvard.

Practice Costs

Considerable work is still in progress in the measurement and allocation of practice costs. Since nonphysician costs are responsible for between 40 and 50 percent of overall resource costs, this work will have a critical impact on the new payment schedule. Thus, we have an intense interest in your work on this subject. Nonphysician costs will affect the new payment schedule in three dimensions: (1) relative resource costs across procedures; (2) payment differentials across geographic areas; and (3) updates in the payment level over time. Detailed and reliable information, directly reflecting medical practice, must be collected and used in all three dimensions.

Although we applaud the attention that the Commission is giving to analyses of practice cost issues, it remains unclear that the funding and efforts devoted to appropriate data collection by the PPRC and HCFA will be sufficient to produce and maintain a credible payment schedule. At stake is the viability of the new payment system and physician and patient confidence that the new payment schedule truly reflects actual resource costs.

Refining the Method for Estimating Practice Costs

The conceptual modification that was made early last year in the method of allocating practice overhead across procedures, moving away from simply allocating these costs proportionately with total work, resulted in a major improvement to the relative value scale. However, a major component of work that remains to be reported relates to distinguishing direct nonphysician costs associated with specific procedures from true overhead. At present, it is our understanding that the Commission

is relying extensively on data from a few large multispecialty practices for this purpose. Since practice circumstances vary so widely among physicians, we are uncertain that such data will be unbiased. For this reason, we encourage you to either develop methods for validating the representativeness of the data being used or engage in much more extensive data collection.

Options for Including Professional Liability Costs

Integration of professional liability insurance (PLI) costs into the payment schedule is of special concern because of the variability and volatility of PLI premiums. This characteristic requires that the component of payment covering PLI costs accurately reflects differences in average premiums by risk classes and rating territories. Although not requiring differentiation of payments at the individual physician level, it does require that the portion of overall payments reflecting PLI costs reflect variations by risk class and rating territory in sufficient detail and that this component be updated more frequently than other components. *It is our view that PLI costs should be directly included in the payment schedule as opposed to being treated with separate periodic lump sum payments.*

Geographic Payment Policies

We continue to support geographic payment variations based on an accurate geographic practice cost index (GPCI) to reflect differences in physician practice costs. In this regard, there are two key points we wish to reiterate from testimony presented to the Commission last year. First, geographic multipliers should reflect valid and demonstrable differences in medical practice costs. Continued reliance on proxies of sometimes questionable validity and timeliness will produce lingering doubts about the credibility of geographic differentials in payment levels. A commitment of resources to the necessary data collection will do much to overcome these doubts.

Secondly, in considering alternative methods of defining the locality boundaries for Medicare payment areas, evidence of geographic differences in resource costs should be balanced against patient access and the need to minimize administrative complexity. In some states, both resource cost data and patient access may indicate that there should be more than one payment area in the state, whereas in other geographic areas, the data might indicate that a single state, or even multiple states, could be combined into one locality.

Finally, we support your efforts to better understand the extent to which current GPCI methods and data accurately reflect she practice costs associated with rural practices. We have already provided PPRC staff with AMA data that bear on this issue, and stand ready to provide whatever additional help that we can to help insure access to rural medical care.

Beneficiary Financial Protection

We are pleased that the Commission chose not to recommend mandatory assignment in its 1989 report, and that assignment will not be mandated under the new Medicare payment schedule adopted by Congress. The legislation does, however, impose limits on physicians' actual charges that are far more stringent than is warranted by your own data and analyses on access and assignment and we continue to oppose these limits. In addition, physicians will be required to accept assignment for services provided to Medicare QMB patients (i.e., those whose coinsurance and deductibles are paid by Medicaid).

The impact analyses presented in your 1989 report found that *charge limits of 115% above the Medicare payment schedule would reduce balance billing below current levels by 73%. and that the percentage of Medicare patients receiving more than $500 in balance bills in a year would be reduced virtually to zero.* With the payment schedule for non-participating physicians established at 95% of the payment schedule, the effective charge limit on unassigned claims under the new payment system will be less than 110% of the payment schedule. Hence, balance billing will be reduced *more than 73% below current levels.*

In view of the severe new restrictions on balance billing in the payment reform legislation, we believe that any recommendations for *additional* constraints would be unjustified and ill-advised. There is no evidence to suggest that special restrictions on balance billing are warranted in those situations in which patients' choice of physicians may be limited and identifying such situations in an administratively practical and equitable fashion would be virtually impossible. On the contrary, the major effect of imposing special restrictions might be to further limit choice rather than to provide meaningful additional "beneficiary protection."

Certainly, there is no meaningful basis for consigning all of the services of radiologists, anesthesiologists, pathologists, and emergency physicians to this category or singling them out for special restrictions. Balance bills for their services will al-

ready be greatly cut by new charge limits applied to (frequently reduced) payment levels. Also, since the Medicare payment schedule will not include specialty payment differentials, it would be inequitable to permit physicians in one specialty to balance bill to the charge limit for a service while precluding physicians in another specialty from doing so for the same service. Mandating assignment in certain settings and circumstances could also create undesirable incentives by, for example, encouraging patients' use of emergency departments for non-emergencies and encouraging use of inpatient radiology services rather than outpatient services. Finally, we urge close attention to the impact of balance billing limits on access to physician services.

Payment to Limited License Practitioners

Incorporation of limited license practitioners into the new Medicare payment system is a complex issue. With the move from CPR to an RBRVS-based payment schedule, the applicable principles become murky. It is clear to us, however, that there is no ready means to apply an RBRVS-based payment schedule beyond MDs, DOs, and oral and maxillofacial surgeons. The RBRVS methodology has been developed for these professions only. It relies on cross-specialty links whose major methodological requirement is that they are agreed to by physicians who share sufficiently deep similarities in background so that they can agree upon links that require the same *physician work*. In addition, the PPRC's recommendation to omit specialty training from the RBRVS, adopted by the Congress, would require reconsideration if the RBRVS is applied to disciplines with training very different from that of MDs and DOs. Thus, application of the new payment system to limited license practitioners should be approached carefully. The PPRC should avoid futile attempts to incorporate such providers directly into the RBRVS and instead should emphasize payment levels that are appropriate given MID/DO payment levels and the actual training, service content, practice costs, and markets of these providers.

CONTROLLING EXPENDITURES AND IMPROVING CLINICAL CARE

Medicare Volume Performance Standards (MVPS)

In contrast to our areas of convergence, we are in profound disagreement with your 1989 recommendation for expenditure targets (ETs) to tie Medicare physician payment updates to expenditure growth. Your stated premise was that ETs, although reflecting broad budgetary concerns, could be met by reducing services "of little or no benefit," without threat to access or quality. Recognizing that ETs, by design, provided no incentives for individual physicians to change their behavior, you asserted that ET-related "collective incentives" would lead physician organizations to engage in activities to alter physician practice. We know of no evidence to support this vague theory. We continue to reject the notion that physicians require "collective incentives" to improve medical practice and furthermore are unconvinced that an ET-type "collective incentive" would necessarily and directly be transferred to individual physician behavior, especially within the current anti-trust climate regarding the U.S. health care industry. Thus, we were extremely gratified that Congress chose to enact Medicare Volume Performance Standards (MVPS) rather than ETs. In choosing this name, and its accompanying policy design, Congress clearly and unambiguously rejected the ET approach, most notably the full automatic link between expenditures and payment updates.

This legislation clearly demonstrates Congressional intent to act every year to establish the MVPS and the payment update. It also requires that HHS and the PPRC *recommend* annual MVPS and payment updates. Of greater importance, these recommendations must be accompanied by detailed analyses of expenditures, utilization, and access; factors that have yet to be completely understood. In addition, Congress will also certainly avail itself of the views of the AMA and other groups representing physicians and their Medicare patients. Thus, Congress will have ample time and means to reach carefully considered decisions. Further, the legislation suggests that both HHS and the Congress will begin their deliberations at the full Medicare Economic Index (MEI) in order to retain the resource base of the payment schedule.

This clear Congressional intent should guide the PPRC's own work on MVPS, which should reflect the circumscribed role volume standards are intended to play in setting conversion factor updates. In particular, efforts to develop sub-national standards and updates must be viewed with considerable skepticism.

Congress can and will use MVPS-related data to make informed payment updates. Certainly these decisions will continue to reflect budget pressures. But we believe that the principal means by which Medicare should target suboptimal utilization are efforts within the scope of the newly established *Agency for Health Care Policy*

and Research and through enhanced medical review. The medical profession has not needed ETs or MVPS to act effectively in this area. Likewise, the Federal Government has increasingly demonstrated its own ability to act to reduce services of little or no benefit without aiming new "collective incentives" at physicians.

The PPRC has a critical role in the annual MVPS and the conversion factor update. Many who supported ETs, including some within medicine, argued that since ETs would reflect all of the components underlying legitimate expenditure growth (i.e., inflation, growth in enrollees, technology, access, etc.), they would furnish a proper basis for payment updates. Indeed, the MVPS provisions detail such elements for consideration by the Secretary. No doubt analysts will generate numbers for each of these factors. We believe, however, that it will be quite difficult to develop acceptably precise estimates for each major component in a manner allowing their sensible combination in the formula underlying the MVPS. This may be particularly true for elements such as *technology change and unnecessary utilization* where attempts to provide quantification have been quite controversial and unconvincing.

Clearly, Congress has identified an alternate path, the "default" mechanism used if it does not establish the MVPS. This default merely sums price and enrollee growth and the five year annual average of volume/intensity and reduces them by a fixed percentage, ultimately 2%. The promise of the finely honed MVPS may simply recede over time to this more prosaic default approach. But we should not pretend that it is anything more and we urge the Commission to address these issues fully in its 1990 Report to the Congress.

We also urge you to be especially wary about fettering physicians and their patients to attainment of any particular budget-driven MVPS. There is simply no reason to think, for example, that the volume/intensity growth in any year should be the "five year annual average of volume/ intensity growth minus 2%." This may be a reasonable policy goal on average. It may even be attainable over time. But it has no real relevance to the true appropriate level of volume in any given year. To pretend otherwise, and to create elaborate structures to link physicians to such standards, will only breed cynicism among physicians and endanger Medicare patients.

There is a better way. Later this morning, I will meet with you again to discuss our views on the improvement of clinical practice. Also, as you know, we are preparing a separate document for your use on the legal issues associated with practice parameters.

Sub-National Volume Performance Standards

Specialty and Type-of-Service MVPS

Although some physician organizations have supported specialty ETs and volume standards, we believe that all physicians stand to lose from such approaches. In particular, specialty and type-of-service standards and updates undermine the fundamental professional commonalities shared by physicians. They encourage clinical and socioeconomic fragmentation. They offer the illusion that only smaller more specialized groups can achieve the best outcomes for their patients and members. They undermine fundamental premises of effectiveness research and practice parameters by focusing on intra-specialty treatment decisions. They place physicians in a narrow target at greater risk that their target will be exceeded as a result of unforeseen treatment advances or forecasting error. For example, between 1982 and 1987, surgery accounted for 42% of Medicare physician expenditure growth, with much of the growth concentrated in a few specialties and procedures. In a surgical MVPS, all surgeons, and only surgeons, would have borne the risk associated with these few services. Finally, such standards may stifle innovations in care by discouraging greater than anticipated growth in particular clinical modalities, "holding harmless" expenditures on services and specialties that exhibit little volume/intensity growth.

Moreover, specialty and type-of-service standards *with differential payment updates* undermine the root premise underlying payment reform, basing payments on relative resource costs. Such updates raise the specter that the full cross-specialty RBRVS can never be updated because relative payments will increasingly reflect non-resource factors as a matter of policy. A specialty-level MVPS could retain resource-based payments within a specialty. But the aim of the RBRVS was never simply to create within-specialty RBRVSs. That goal could have been satisfied at much lower cost to the Federal Government and the medical profession. Instead, physicians have been told that an RBRVS payment schedule was so essential that payment differentials not based in resource costs must be eliminated, even at the

risk of potentially severe financial dislocations. It is inconceivable that this principle could now be casually discarded.

Also, specialty MVPS, even without differential payment updates, pose many of the same obstacles that led the PPRC and many within the medical profession to avoid specialty differentials. For example, how do you identify a specialist or a specialty service? is a surgeon and what is surgery? These questions assume crucial importance if a specialty MVPS is intended to encourage peers to work together on utilization. Moreover, how can you reject specialty differentials based on training as violating a principle of equal payment for same service while allowing differentials based on performance against a "volume standard?"

How would a specialty or type-of-service MVPS be established and updated? We outlined above our concerns that many MVPS components will be very difficult to estimate. These factors will be even more elusive for specialty or type-of-service, especially in the stifling context of competition for shares of an overall MVPS. Separate MVPs calculations would require profound and radical social judgments on the proper configuration of medical practice. Simply basing volume standards on past trends is still disturbing, consigning low growth services to a low growth allowance. Such an approach is especially questionable if payment reform is intended to alter incentives to provide certain services. In sum, specialty and type-of-service volume standards will prove woefully inflexible in the face of rapid changes across such artificial boundaries in patient demand, medical practice, and technology.

Congress has, of course, given HHS discretion to recommend *different updates by category or group* of services. It has required HHS to calculate a surgical MVPS, and allowed the Department to define additional service categories by regulation. Inherent in this authority is the ability to recommend against differential updates. We hope that the PPRC's experience with the surgical MVPS will provide important insights into the question of additional MVPS categories. We ask that you be very careful in evaluating HHS recommendations for differential updates based on the surgical MVPS or any other factor.

Geographic MVPS

The payment reform legislation clearly established the hard won principle that geographic payment differentials shall be based on resource cost differences and access considerations. At the same time, the Secretary must report to Congress by July 1, 1990 on the feasibility of *geographic MVPS*. We understand that there are substantial issues of data adequacy and geographic variability in utilization and its year-to-year growth. In addition, of course, are broader questions, like proper state-level rates of technology change. Our understanding is that the PPRC would deal with such issues through a variety of complex adjustments. For example, your 1989 Report suggested the option of differential updates only for areas of highest or lowest utilization. Such attempts to moderate the effects of a geographic MVPS only serve to suggest that perhaps this is not the best route.

The state is still a large unit in which to influence physician behavior through MVPS. Incentives clearly will be diluted almost as much as at the national level. Indeed, a state MVPS will require adjustments that further diminish these incentives. At the same time, these adjustments will needlessly explode the complexity and administrative requirements of the new "simplified" payment system. What will state MVPS really produce? And at what cost? Certainly we need experience with the national MVPS before taking such an untried step.

Group "Carve-Outs"

The Secretary of HHS also has a Congressional mandate to study MVPS *"carve-outs" for groups of physicians,* and is to report by April 15, 1991. The PPRC must review and comment by May 15, 1991. Clearly many technical issues exist, and we eagerly await these reports. But analyses to date leave us very concerned. We especially challenge the logic of the underlying notion that "efficient physicians" should be removed from the general MVPS. Even if a separate MVPS would only reward truly efficient practices, and not those with less ill patients, a carve-out will make those physicians least able to increase clinical "efficiency" most subject to the overall MVPS, which will be increasingly difficult to meet. It would discriminate against physicians for whom joining a group is neither feasible or appropriate. Finally, it might subject those Medicare patients that have chosen not to join an HMO or PPO to financial incentives that they have chosen to avoid.

PHYSICIAN PAYMENT IN THE MEDICAID PROGRAM

The AMA continues to vigorously support expansions in the Medicaid program as one component of a comprehensive national strategy to provide adequate health in-

surance for all Americans. The Medicaid program is falling far short of its goal of providing a medical care safety net for those in need. An estimated 60 percent of individuals who live in families with incomes below the Federal poverty level—about 20 million people—are not covered by Medicaid.

We share your concern that inadequate payment levels may discourage physicians and other health care providers from participating in the Medicaid program. Hence, as part of our broad Medicaid reform proposal, and in the context of adequate funding, we support setting Medicaid physician payment rates at Medicare levels to improve Medicaid beneficiaries' access to needed care. Of course, we urge the Commission to proceed cautiously in making physician payment recommendations that, in the absence of such comprehensive Medicaid revisions, could have adverse consequences for eligibility, access, and benefits.

Our support for an RBRVS has focused on Medicare. Beyond support for setting Medicaid payments at Medicare levels, we have not formally considered whether or not an RBRVS *per se* would be appropriate for Medicaid. In evaluating this issue, it is essential to consider how patient access might be adversely affected if an RBRVS were put in place with "Medicaid budget neutral" conversion factors. Medicaid payments are generally so far below private sector and current Medicare levels that RBRVS-based payments derived from current Medicaid funding levels could threaten Medicaid patients' access to procedurally-oriented services.

CONCLUSION

The AMA appreciates this opportunity to express its views to the Commission. You have clearly assumed a burdensome responsibility and the AMA will be pleased to provide all of the assistance that it can to help assure that implementation of physician payment reform is equitable and rational. I will be pleased to respond to any questions.

Enclosure.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION TO THE SUBCOMMITTEE ON SELECT REVENUE MEASURES, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, FEBRUARY 22, 1990

RESTORATION OF THE DEDUCTIBILITY OF INTEREST ON EDUCATIONAL LOANS

Mr. Chairman and Members of the Subcommittee: My name is Mark S. Litwin, M.D. I am a resident physician in my fifth year of a six-year residency program in urological surgery at Brigham and Women's Hospital in Boston, Massachusetts. I am also Chairperson of the Governing Council of the American Medical Association's Resident Physicians Section, which represents the concerns of the Association's resident physician members. With me is Stacey Carry, M.D. a resident physician in her fourth year of a five-year residency program in pathology at the University of Utah Affiliated Hospitals in Salt Lake City. Accompanying us is David L. Heidorn, J.D., of the AMA's Department of Federal Legislation.

I feel privileged to appear before you to say that the American Medical Association appreciates this opportunity to share with the Subcommittee on Select Revenue Measures the Association's concerns about how recent Federal tax and budget measures threaten the ability of some otherwise excellently qualified individuals to become physicians. Unless these measures are reversed, the availability of physicians to deliver necessary medical care in some areas of the country and in some medical specialties could be severely limited.

First, the phase-out of educational loan interest deductions instituted in the Tax Reform Act of 1986—which classified both educational loans and loans to purchase consumer goods as "consumer loans"—took away from resident physicians and young physicians starting up medical practices the ability to deduct interest payments on these loans. Interest deduction softened the blow of beginning to pay back medical educational debt that, in recent years, has risen beyond anyone's imagination—from a mean level of $19,700 for each individual with such debt in 1981 to $42,200 in 1989.

Now, just as these young physicians are beginning to feel the full extent of the Tax Reform Act's impact on their personal budgets, Congress, in an effort to find budget savings of its own through the Omnibus Reconciliation Act (OBRA) of 1989, reduced the ability of resident physicians to defer repayment of their major student loans while they complete their necessary medical education in residency programs. As a result, many resident physicians this year will have to begin making loan payments of between $500 and $700, which they did not expect when they entered the loan agreements.

We know that a great many resident physicians, including Dr. Carry, have incomes and living expenses that make such payments impossible and make it difficult for them to complete their residency training programs. Further, some bright, highly qualified young people now looking to medicine as a career and some medical students already in training will not be able to become physicians because they lack the financial resources to carry them through the long and, now, even more financially burdensome medical education process.

We are well aware that the student loan deferment issue is not a direct responsibility of this Subcommittee. However, the AMA urges that, when considering the restoration of the student loan deduction, the members of this Subcommittee consider the overall financial situations in which many young physicians, especially resident physicians, now find themselves and how these recent changes will affect where young physicians decide to practice medicine and the kinds of patients they will be able to serve. These economic issues will even determine whether some young people will choose to become physicians at all.

Student Loan Interest Deductions

The American Medical Association endorses the statement of the Student Loan Interest Deduction Restoration Coalition (SLIDRC), from whom you also are hearing testimony today. This nation's tax laws reflect in many ways our national character and concern, such as the support given families through tax exemptions for dependents and charitable giving through tax deductions. Home ownership is favored by allowing taxpayers to deduct interest on home mortgages. Through the Tax Reform Act of 1986, Congress, in part, sought to limit our reliance on debt by phasing-out deductions for interest on consumer loans. Unfortunately, the wide sweep of that policy treated educational loans the same as consumer loans for automobiles and department store credit card purchases.

We fail to see the similarity between consumer debt and educational debt. At a time of wide-spread concern over education and its importance to our competitiveness in a global economy, we cannot afford a message that educational loans are the same as consumer loans. As the SLIDRC statement points out, the estimated $700 million in revenue that would be lost over five years if the deduction were restored would be a cost-effective investment in the economic benefits that would follow from a better-educated workforce. Mr. Chairman, education loans are investments in our nation's human capital. Such investments in our future need to be encouraged through tax policy, not discouraged.

Deferment of Resident Student Loans

Prior to the enactment of the OBRA of 1989, resident physicians in training programs that had a major affiliation with a university—about 75 percent of the more than 81,000 resident physicians on duty in the United States—were able to be considered as having "in school" status, thus qualifying them, as others in school, for a full deferment of the Stafford Student Loans and other student loans under Title IV of the Higher Education Act during their residency training. As a budget measure projected to save the Federal Government $10 million a year, OBRA of 1989 prohibited resident physicians from being classified as "in school." As a result, resident physicians, who generally require between 3 and 6 years, even up to 7 years, of residency training, with fellowship programs that follow for some specialties, are limited to a two-year deferment under an internship classification.

Impact on Health Care

Resident physicians and young physicians are disheartened by these recent changes in tax and budget policy. The denial of "in school" status, coupled with the elimination of student loan interest deductions, will make the repayment of loans during residency training that much more onerous. In turn, this will threaten the ability of many resident physicians to complete their medical training. It should follow that some young physicians will be forced to establish medical practices not where they are needed, in underserved rural and inner-city areas, but in areas where they are certain to earn higher incomes to pay off the large debts they have accumulated to become physicians.

According to the American Association of Medical Colleges, in 1988, 83.4 percent of all medical graduates, or those who are ready to enter residency training programs, had educational debt, with an average total indebtedness of $38,489 ($42,200 in 1989). Of those with debt, 24 percent had a total educational debt of over $50,000. We have heard of some resident physicians with $90,000 in student loans. Monthly student loan repayments of at least $500 to $700 for resident physicians would not be uncommon on typical monthly salaries of $2200 to $2300.

For resident physicians who do not receive financial support from their parents, who are raising families, or who have spouses who are students or who otherwise cannot provide adequate support, an extra $500 to $700 a month does not suddenly materialize in their budgets. This is especially true for those who may be in residency programs in urban areas or areas near large universities where housing costs can be especially high. Dr. Carry is one such resident physician who finds herself in an economic situation that, beginning in July, will be vary difficult. She will share with you her thoughts and concerns on how these policy changes will affect her life and professional plans, which are to practice her specialty in pathology in an underserved area in the West. The AMA has spoken to many residents in similar circumstances and is in the process of finding out just how extensive their problems are.

Conclusion

The AMA is committed to the principle that qualified individuals who want to become physicians, no matter their financial or social backgrounds, should have the opportunity to do so. The inability to deduct student loan interest and to defer student loan repayment while completing a medical education will keep some otherwise deserving individuals from becoming physicians and force too many of those who are financially able to become physicians to choose medical practices in more lucrative specialties and in geographic areas that already may be well served.

Mr. Chairman, the current tax policy on educational loans is short-sighted and should be changed. Restoring student loan interest deduction would be one way that this Subcommittee could help to ensure access to necessary health care in all areas of this country and to ensure that medical education is available to all those who are qualified, not an economically select few.

DR. GARRY'S STATEMENT

Mr. Chairman and Members of the Subcommittee: I am one of the many resident physicians affected by recent changes in Federal tax and budget policies that Dr. Litwin describes. I honestly do not know how I am going to complete my medical education or how I am going to begin a practice in the type of community that I have pictured for my family.

I am in my fourth year of a five-year residency program in pathology at the University of Utah Affiliated Hospitals in Salt Lake City. My goal has been to practice pathology in a smaller town in the West. This most likely would be an underserved area, as many areas of the West are.

Let me give you an idea of the economic situation that I find myself. From my residency program, I currently receive a salary of $1653 a month. My husband is a geologist and an excellent finish carpenter, but a severe back injury has limited him to a geology consulting business with an average monthly income of $350. Our combined monthly income of $1858 has been barely adequate to cover our current monthly expenses that average $1786 a month, including a mortgage payment of $586.

In July, due to the sudden, unexpected change in the student loan deferment policy, I am facing an additional monthly payment of $568 on my student loans, which have added up to a total of $26,600 in government insured loans. Although I expect my monthly salary to be raised about $145, we are still facing a deficit of more than $350 a month.

Forbearance, an option residents were given at the same time the "in school" deferment was taken away, may be a last resort to get me through one more year of residency, but the interest accumulated through any forbearance period will drive up my monthly payments when I begin practicing. I also have close to $11,000 in non-government loans from several non-profit organizations and private investors that need to be paid back within several years after my residency training is finished.

Given this situation, I do not know how I will be able to accept a position in a rural community where there is a higher need for pathologists and where my husband and I would like to settle. I look at the debt I have accumulated and my situation tells me to get as high-paying a position as possible.

I hope that will not be true. It's not why I went into medicine. But it is beginning to seem like some of the disillusionment that I hear from older physicians may be true. I will get through this somehow, but sometimes I wonder if it has been worth it. I am concerned that potential physicians who are behind me in the education process and are making career decisions will decide that medicine is not worth these difficulties.

We again urge this Subcommittee to restore the student loan interest deduction. It will not solve every problem I have as a resident physician or will face as a young

practicing physician, but it will help address some of my financing concerns. it would also reflect the commitments to education and adequate access to health care that I know we all share.

Dr. Litwin and I will be happy to answer any questions you have.

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, June 13, 1990.

Hon. LLOYD BENTSEN, *Chairman*
Committee on Finance,
Dirksen Senate Office Building,
Washington, DC

Re: Hearing of March 22, 1990, Follow-up Response

Dear Senator Bentsen: This letter responds to the question you have submitted to me as a follow-up to my appearance for the AMA before the Committee at the March 22, 1990 hearing on the Administration's budget proposals for Fiscal Year 1991. Specifically, this letter responds to your question regarding the dilemma Congress faces in evaluating proposals to achieve "savings" from physician reimbursement through either an across-the-board cut or a cut that exempts primary care services and effectively increases any cuts imposed upon other services.

As you well know, the AMA does not support further cuts in payment for physicians' services under Medicare, for all of the reasons set forth in our formal statement to the Committee on March 22, 1990. However, we do feel the responsibility to answer your specific question.

• In the interest of fairness, the AMA believes that if Medicare "savings" need to be generated from payments for physicians' services, this should be accomplished via an across-the-board action.

Both of the past two budget reconciliation acts have exacted significant reductions in reimbursement for so-called "overvalued" services. At the same time, the roughly 16% of Medicare payments for a narrowly defined grouping of primary care services have been allowed payment updates. At this time, with the physician payment reform initiative scheduled to begin implementation in 1992, we believe that payment for all physicians' services should be eligible to receive the maximum update possible through an increase in the Medicare Economic Index.

A major concern of the AMA is that further service- or specialty-specific reductions and differential updates in 1991 are inconsistent with the directions set just last year by Congress in mandating a detailed, formal transition to the resource based fee schedule beginning in 1992. The scheduled phase-in recognizes that adjustments with potentially dramatic shifts will be made in payment levels and provides a carefully considered plan to phase-in these changes. Therefore, large 1991 reductions for certain services or geographic areas could compound the differentials and severely disrupt the availability of care for certain services or in certain areas. We also are concerned that service- or specialty-specific actions for 1991 run the risk of over-shooting changes that will be brought about by the phase-in of the new payment schedule.

An alternative approach that in large part would be consistent with the theory of equal across-the-board treatment between services would be to allow a greater reimbursement increase for those physicians whose services are under-reimbursed due to the location where they provide services. To some degree, Congress has addressed this issue by allowing a bonus payment for services provided in designated Health Manpower Shortage Areas. A differential across-the-board update policy that would allow a greater reimbursement increase for those physicians in historically under-reimbursed geographic areas, typically those physicians in rural America, would work to maintain access levels in the very parts of the country where unrealistic Medicare reimbursement levels are forcing physicians to reconsider their ability to provide care to the elderly and disabled.

As you deliberate on these and other budget matters that will have a direct impact on health care delivery, we welcome the opportunity to be of assistance.

Very truly yours,

JOHN J. RING, *MD, Chairman, Board of Trustees.*

PREPARED STATEMENT OF LOUIS W. SULLIVAN

Mr. Chairman and members of the Committee, I am honored to appear before you today to discuss the budget priorities for Fiscal Year 1991 that President Bush and I have for the Department of Health and Human Services. With your permission, I would like to submit this statement for the record to accompany my oral remarks. In this statement, I will present President Bush's budget proposals affecting programs within the jurisdiction of the Finance Committee.

INTRODUCTION

The 1991 budget for the Department of Health and Human Services (HHS) of $464 billion will enable the Department to continue support for its program responsibilities, including providing essential benefits and services for the nation's most vulnerable individuals and families—the elderly, the sick, the disabled, and the poor.

Under current law, this budget represents an increase of 7.7 percent compared to 1990. Entitlement programs, which make up 95 percent of the total HHS budget, will grow at a rate of 7.8 percent. However, when new legislation is considered, the growth in entitlement programs is limited to 6.4 percent. Programs whose funding is discretionary, such as some of those administered by the Public Health Service, will have a budget increase amounting to 7.4 percent over 1990 levels. Both of these increases entitlement and discretionary—are well in excess of the 4.2 percent the Administration currently estimates for inflation in 1991.

Carrying out the Department's mission requires prudent management of all HHS programs, but especially the entitlement programs because of their size and rates of growth. Spending smart for our entitlement programs helps both to provide resources to fund additional benefits for those entitlement programs and to create opportunities for support of other key goals. Spending smart can help provide the resources to improve access to health care, especially for minorities. It can move us closer to President Bush's goal of making the Head Start experience available to all eligible four-year-old children. It can create the resources for saving lives through drug abuse prevention and treatment. It permits us to invest in the future health of all Americans through biomedical and behavioral research.

Mr. Chairman, let me now summarize the priorities that President Bush and I have for the Department of Health and Human Services for the 1991 Budget.

MEDICARE AND MEDICAID

We are making legislative proposals that would reduce Medicare outlays by $5.5 billion in 1991 compared with current law. These proposals would reduce the annual rate of growth of Medicare from 9.9 percent to 4.6 percent. In addition, we are proposing legislative changes that would increase Medicare revenues by $1.9 billion. Thus, our Medicare proposals would reduce the deficit by $7.4 billion in 1991. Total Medicare outlays in 1991, including the effect of regulatory and legislative proposals, are estimated at $110.5 billion.

Federal mandatory Medicaid expenditures under the 1991 budget would increase by $4.8 billion, to $45.0 billion, a 12 percent increase over the 1990 level. Three hundred million dollars of the 1991 increase in Medicaid spending will fund the recently enacted mandatory expansion of Medicaid to cover pregnant women, infants and young children from families with incomes up to 133 percent of the poverty level, which is consistent with the President's proposal last year. We have proposed no further mandatory expansion at this time, but will continue to encourage States to use the authority they now have to fund care for this population with incomes up to 185% of poverty.

Our 1991 budget for Medicare has four major themes: (1) encouraging managed care, (2) assuring appropriate care, (3) preparing for physician payment reform, and (4) assuring prudent purchasing practices.

In the category of managed care, we are proposing increased expenditures. To assure appropriate care, our budget would significantly increase funding for research activities under the newly created Agency for Health Care Policy and Research, which this Committee was instrumental in creating. This research would help us to gain knowledge about the effectiveness of medical practices and procedures.

To prepare for physician payment reform, we are proposing a number of legislative changes, extending those changes made by the Congress in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) designed to prevent building into the new payment system the inequities of the current system. To assure prudent purchasing practices, we are proposing to establish Medicare payment rates that reflect costs

incurred by efficient providers. Public and private sector payers are increasingly using prudent purchasing methods.

In OBRA 89, the Congress enacted measures aimed at improving equity in Medicare payment levels for services. Many of these measures reduced Medicare payment levels for services, because excessive payments are as inequitable as insufficient payments. This budget continues and expands the thrust of OBRA 89. We are proposing additional actions aimed at improving equity in payment levels for both physician and non-physician services.

Health care costs are one of the fastest growing segments of the Federal budget. Medicare benefit costs have doubled every five years since 1975, and current projections indicate that Medicare expenditures will exceed spending for Social Security soon after the turn of the century. In 1991, approximately 31.4 million people aged 65 or older and 3.3 million people under 65 with disabilities or who suffer from end-stage renal disease (ESRD) will be covered by Medicare. To assure the financial solvency of such an important program, we must be prudent in the services we purchase on behalf of these beneficiaries, and we must be observant in our duty to conserve the Medicare trust funds. I firmly believe that the Administration's 1991 budget serves the Medicare program and its beneficiaries well in these respects.

ENCOURAGING MANAGED CARE

Medicare

In the 1991 budget, we are proposing to encourage a major expansion in the enrollment of Medicare beneficiaries in managed care programs. We believe that managed care offers beneficiaries a number of advantages over fee-for-service Medicare, including ease in coordinating care in an increasingly complex health care system. Frequently, managed care systems, particularly HMO's, emphasize preventive care services. In addition, managed care systems are frequently able to provide additional services as a means of attracting customers and—especially when coupled with Medigap insurance—have a significant incentive to eliminate unnecessary and inappropriate services.

Our managed care initiative includes two Medicare proposals:

• *Increase Payments to Medicare's Risk-Contracting Health Maintenance Organizations (HMOs).*—(Costs of $100 million in Part A and $80 million in Part B in 1991)

Medicare now pays risk-contracting HMOs at a level equal to 95 percent of the estimated per capita cost to Medicare for beneficiaries served by fee-for-service providers, called the adjusted average per capita cost (AAPCC) To encourage greater use of health maintenance organizations (HMOs), the budget proposes to increase the Medicare payment level for risk-based HMOs from 95 percent to 100 percent of the adjusted average per capita cost (AAPCC). This change would increase the attractiveness and availability of managed care options. A portion of the increased payments would be provided directly to beneficiaries in the form of a rebate by the HMO. The remainder of the payment increase would be provided to the HMOs and would allow them to expand benefits or reduce enrollee premiums.

• *Medicare Plus*—Under this proposal, the Department would encourage the introduction of Medigap policies that combine Medigap and Medicare services into one package provided by a managed care plan. Medicare beneficiaries enrolling in "Medicare Plus" plans could expect to receive Medigap coverage reduced premiums compared with coverage under standard Medigap policies. As the cost of purchasing Medigap policies continues to increase, we believe that the Medicare Plus option is a very valuable one for beneficiaries. we also believe that beneficiaries would benefit from the quality and coordination of services Medicare Plus plans would provide. By coordinating Medicare services with a Medigap insurance plan, Medicare Plus providers would have a built-in incentive to reduce unnecessary utilization of services. Medicare beneficiaries would be notified by HCFA of the availability of the plans in their area.

• *Medicaid Managed Care* (Cost of $25 million for FY 1991)—To improve access to high quality health services for Medicaid enrollees, the budget includes a legislative proposal that will increase and enhance the use of managed care. Enrollment in a managed care plan would ensure Medicaid beneficiaries including a physician/case manager to serve as their primary source Of care and coordinate any special services they need.

This proposal would:

• Provide enhanced Federal matching rates for States to promote the use of managed care over traditional fee-for-service arrangements. Initially, only increased

managed care enrollment would receive enhanced matching. Gradually, this enhancement would apply to all managed care enrollment and would be combined with a reduction in matching payments for certain recipients not enrolled in managed care programs. The reduction would not apply to rural or medically underserved areas or to institutionalized individuals and could no more than offset the cost of enhanced matching for managed care.

- Allow States the option of implementing mandated managed care programs through their State plan without having to apply for waivers. Quality reviews would be required.
- Relax specific enrollment requirements for certain Medicaid HMO's.

We believe that these proposals will assist states in developing an atmosphere in which managed care programs can flourish and provide improved access and higher quality health care to the Medicaid population.

PART A—HOSPITAL INSURANCE

Growth in Medicare expenditures for inpatient hospital Services has continued to moderate under the Prospective Payment System (PPS). Restraint in the PPS update factors has also reduced excessive average hospital operating margins. However, there remain subsidies in the payments to hospitals under Part A which are clearly unwarranted. The budget contains proposals to reduce Part A outlays by almost $3.4 billion in 1991 and $22.3 billion over five years. In addition to continuing FY 1990 policies relating to capital, the budget strives to protect rural hospitals.

- *Reduce Capital Payments to Rural Hospitals by 15 Percent and Urban Hospitals by 25 Percent* (Savings of $1,530 million in 1991)

Current law provides for a 15 percent reduction in capital payments to hospitals between January 1, 1990 and September 30, 1990. This payment provision, however, does not maintain the payment reduction after FY 1990. This proposal would continue the FY 1990 level for small rural hospitals (under 275 beds) in recognition of their unique status in assuring continued access to quality care. For urban hospitals and large rural hospitals, the 1991 payment level would be reduced by 25 percent. Savings reductions will continue in the outyears with the implementation of prospective payment for capital, scheduled to begin in FY 1992.

Paying hospitals less than their full cost of capital provides them with a strong incentive to evaluate the effect of capital investment on reductions in operating costs. Such an incentive is necessary in order to adequately restrain growth for this last major class of hospital costs still paid as a "pass through" on a reasonable cost basis. Incorporating capital into PPS at 100% will establish the proper incentive to ensure capital expenditures are cost-effective.

- *Set the Prospective Payment System (PPS) Update at Market Basket Minus 1.5 Percent which is an update of 4.1* (Savings of $640 million in 1991)

Although the rate of increase in outlays for inpatient hospital services has continued to slow in recent years, efficiencies in the hospital system can still be achieved. A PPS update that averages 1.5 percentage points less than the full market basket will encourage further efficiencies while providing hospitals with an overall update that is sufficient to maintain high quality health care.

- *Eliminate Return on Equity (ROE) Payments to Skilled Nursing Facilities (SNFs)* (Savings of $70 million in 1991)

Current law requires payment of a return on equity (ROE) for proprietary skilled nursing facilities (SNFs). Equity includes all capital, net of depreciation, used for patient care, including loans from investors. SNFs are the only class of providers for which Medicare pays ROE, largely because they are still paid on a cost basis. We are proposing to eliminate these payments.

- *Reduce the Factor Used in Making the Indirect Medical Education Payments to 4.05 Percent* (Savings of $1,030 million in 1991)

Medicare pays teaching hospitals for indirect costs associated with approved intern and resident programs. The payment adjustment is based on a formula that relates the operating costs per case to the number of interns and residents per bed. The budget proposes to reduce the factor used to calculate the indirect medical education payment from 77 percent to 4.05 percent.

GAO, ProPAC, IG, CBO and HCFA have produced studies that indicate that the appropriate adjustment is well below the current 7.7 percent. Based on these studies, the Department has concluded that reducing the adjustment factor to 4.05 per-

cent would result in payments that more accurately reflect percent would result in payments that more accurately reflect the estimated effect of teaching programs on average operating costs per case.

• *Reform Graduate Medical Education (GME) Payments* (Savings of $170 million in Part A and $35 million in Part B in 1991)

This proposal would establish a per resident payment derived from the national average of FY 1987 salaries paid to residents updated by the CPI. Interns and primary care residents would be weighted at 180 percent of the per resident amount, non-primary care residents in their initial residency period would be weighted at 140 percent, and non-primary care residents beyond the initial residency period would be weighted at 100 percent. This proposal would decrease the present diversity in GME payments that has resulted from historical patterns in hospital accounting.

Payment for the direct costs of medical education for nurses and allied health professionals would not be affected by this proposal.

• *Cab Intern- and Resident-to-Bed (IRB) Ratios at FY 1989 Levels* (Savings of $10 million in 1991)

Currently, there is no limit on the IRB ratio used to determine the indirect teaching adjustment. The budget proposes to cap the IRB ratio at FY 1989 levels. This proposal will discourage hospitals from closing beds solely to raise their IRB ratios and reap "windfall" payments.

The budget also includes the following Part A revenue proposal:

• *Include Under Medicare State and Local Employees Hired Before April 1, 1986* (Revenue Increase of $1,866 million in 1991)

COBRA mandated Medicare coverage and payment of Hospital Insurance taxes for new State and Local government employees hired after March 31, 1986. The budget proposes making Medicare coverage and Hospital Insurance taxes mandatory for *all* State and Local employees, including those hired before April 1, 1986.

This proposal would ensure that Medicare coverage would be available to all State and Local government workers. In addition, it would remove an inequity in the financing of Medicare coverage. Many State and Local employees become eligible for Medicare on the basis of short periods of work during which they are covered by Social Security (or because of their spouse's eligibility) whereas most Medicare beneficiaries make contributions to the Hospital Insurance Trust Fund during all of their working years. The Office of the Inspector General examined a sample of retirees from State and local agencies not covered by Medicare and found that and local agencies not covered by Medicare and found that approximately 85 percent of the retirees were nonetheless enrolled in Medicare Part A. Since these individuals receive full Medicare benefits, this proposal would ensure that these individuals contribute their fair share to the Hospital Insurance Trust Fund over time.

PART B—SUPPLEMENTARY MEDICAL INSURANCE

In the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), Congress enacted a three-part physician payment reform—Medicare volume performance standards, a resource-based fee schedule, and beneficiary protections. These measures will help to restrain growth in the volume and intensity of services, improve equity in payment levels for physician services and provide financial protection to beneficiaries from physician charges. Consistent with the implementation of physician payment reform, the Congress reduced Medicare payment levels for certain overvalued procedures and services.

This budget continues and expands the thrust of OBRA 89. Prior to implementation of the new Medicare payment system, we are proposing additional actions aimed at improving equity in payment levels for over five years. With these proposals, growth in Medicare Part B benefit costs is estimated to be 6.3 percent in FY 1991, compared with an 11.2 percent increase without the proposed legislation.

Let me emphasize that none of our legislative proposals would reduce benefits. Our Part B legislative proposals would reduce the medical costs of beneficiaries by reducing the coinsurance amounts that they must pay; these costs would be reduced by reducing excessive payment rates for certain physician and other Part B services. Savings from lower copayments would total and estimated $375 million in 1991, or about $1 per month per beneficiary. These savings would nearly double in 1992. Let me also add that limits on extra billing, enacted by the Congress last year with strong Administration support as part of physician payment reform, will save Medi-

care beneficiaries an estimated $1.5 billion a year, or about $4 per month per enrollee.

Physician Payment Proposals

The savings initiatives regarding payment to physicians are as follows:

• *Update Only for Primary Care Services* (Savings of $450 million in FY 1991)

To improve equity in relative payment levels for physicians services, for 1988, 1989 and 1990, the Congress provided full updates only for primary care services. For 1991, we are proposing to provide full customary and prevailing charge updates only for primary care services and to freeze for 1991 the customary and prevailing charge update for non-primary care services. We are also proposing to implement in 1991 a consolidation of customary and prevailing charge screens, currently scheduled to be used in 1992 as the basis for the transition to the fee schedule.

• *Reduce Payments for Certain Overvalued Procedures* (Savings of $110 million in FY 1991)

In OBRA 1989, the Congress reduced payments for selected overvalued procedures by one-third of the amount by which they were determined to be overvalued compared to an estimated resource-based fee schedule, up to a maximum reduction of 15 percent. For 1991, we are proposing to reduce payments for overvalued procedures by two-thirds of the remaining amounts by which they are overvalued, up to a maximum reduction of 25 percent.

• *Reduce Payments for Overvalued Localities* (Savings of $50 million in FY 1991)

In OBRA 1989, the Congress determined the geographic practice cost index (GPCI) that would be used under the fee schedule. The Congress also applied a GPCI in the overvalued procedure reduction.

For 1991, we are proposing to reduce payments for certain procedures in localities where payments are overvalued relative to the national average, once that average has been adjusted to account for differences in practice costs among areas. The maximum reduction for any procedure in a locality in 1991 would be 25 percent. The procedures covered would exclude those covered by our other proposals (i.e. overvalued procedures, radiology, anesthesiology and technical components) low volume procedures, or procedures the payment for which is expected to increase under a resource-based fee schedule.

• *Reduce Radiology and Anesthesia Fees* (Savings of $230 million in FY 1991)

In OBRA 1989, the Congress reduced payments for radiology and anesthesia services: radiology fees were reduced by 4 percent and a change was mandated in payment for anesthesia time. For 1991, we are recommending reductions in Medicare payments for radiology and anesthesia services in order to further reduce their overvaluation.

We are proposing that radiology and anesthesia fees be reduced by the amount that current fees exceed an estimated resource-based fee schedule. The fee schedule would be estimated by reducing the 1990 national average conversion factor by 10 percent (less than the full amount we estimate these services are overvalued). The maximum reduction for any locality in 1991 would be 25 percent.

In addition, for 1991, we are proposing to pay the same amount for anesthesia service, regardless of whether an anesthesiologist personally performs the anesthesia service or medically directs a certified registered nurse anesthetist (CRNA) who furnishes the anesthesia. Accordingly, Medicare would pay the anesthesiologist for medical direction an amount equal to the difference between the payment if the anesthesiologist personally performed the service and the Medicare payment for the CRNA. The Medicare payment for CRNAs would not be reduced.

• *Reform Payments for Assistants-at-Surgery and Surgical Global Fees* (Savings of $170 million in FY 1991)

For FY 1991, we are proposing that Medicare pay the same amount for a surgery regardless of whether or not the primary surgeon elects to use an assistant-at-surgery to whom Medicare makes a separate payment. The Medicare payment for the primary surgeon would be reduced by the amount of the Medicare payment for the assistant-at-surgery used by such surgeon. Limited exceptions would be allowed. This proposal is based on the wide geographic variation in the use of physicians as assistants-at-surgery and on the substantial use of primary care physicians as assistants-at-surgery, which suggests that the use of a physician as an assistant-at-surgery, as opposed to other medical personnel, is largely at the discretion of the primary surgeon.

Medicare payments for surgery reflect a global fee that includes the surgery as well as in-hospital visits and post-discharge visits by the surgeon. For 1991, we are

also proposing to reduce Medicare payments for surgical global fees to account for the reduced number of inpatient visits by the primary surgeon because of the reduction experienced in length of stay of Medicare beneficiaries over the past few years. The reduction would be either a procedure-specific amount (where data are available) or 2 percent across-the-board.

• *Phase-in Increases for New Physicians* (Savings of $50 million in FY 1991)

OBRA 1987 limited the fees of new physicians to 80 percent of the prevailing charge, except for primary care services and services in rural health manpower shortage areas. OBRA 89 continued, for one year, to phase in increases for new physicians by limiting payments to second year physicians to 85 percent of the prevailing charge.

We are proposing to continue to phase in Medicare payment increases for new physicians, for 1991 under prevailing charges, and for 1992 and thereafter under the fee schedule. Payments would be 90 percent for third year physicians, 95 percent for fourth year physicians, and 100 percent of the fee schedule amounts for fifth year physicians. We are also proposing to extend this policy to other practitioners reimbursed on a fee-for-service basis.

• *Technical Components of Diagnostic and Radiology Tests* (Savings of $60 million in FY 1991)

Currently, Medicare pays technical component fees associated with diagnostic and radiology services over and above the professional interpretation associated with such service to cover the equipment, technician and supply costs associated with these services. For 1991 we are proposing to apply a cap at 100 percent of the national median of the technical component of radiology services and diagnostic tests, similar to the cap on carrier-specific fee schedules for clinical laboratory diagnostic tests.

Because of the wide dispersion in current geographic payments for radiology and diagnostic tests, we believe that a cap is appropriate. If the tests can be provided in half the carriers for a fee less than the median, they should be able to be provided in other carriers at the median.

• *Physician Assistant Offset* (Savings of $5 million in FY 1991)

OBRA 1987 authorized direct Medicare payment for certain services of physician assistants (PAs) and also authorized reductions in Medicare payments otherwise made to hospitals and nursing homes in order to eliminate estimated duplicate payment for costs attributable to direct billings for PA services. For 1991, we are proposing to eliminate duplicate payments for PA services furnished in hospitals by offsetting them from the hospital's Medicare payments. An exception would be made for PA services furnished in hospitals located in manpower shortage areas.

• *Voluntary Hospital Physician Participation* (No Cost)

Currently, physicians have the option to voluntarily sign Medicare participation agreements whereby they agree to accept assignment for all services provided to Medicare beneficiaries for the following year.

For 1991, we are proposing to allow hospitals the option to voluntarily become Medicare participating physician medical staff hospitals. A hospital would have the opportunity to sign an agreement with Medicare whereby the hospital would guarantee that assignment would be accepted for the following physicians' services provided in that facility: emergency services, radiology, anesthesia and pathology services and consultations. A hospital would be free to advertise its status as a Medicare participating medical staff hospital and thus attempt to improve its competitive position. Beneficiaries choosing these hospitals would receive additional financial protection in situations where they today have little choice of the physicians providing these services.

NON-PHYSICIAN PROPOSALS

• Reduce Hospital Outpatient Payments (Savings of $670 million in 1991)

In order to improve equity in Medicare payments for all Medicare services, we are proposing a 10 percent across-the-board reduction in Medicare payments for certain hospital outpatient services, beginning in 1991. Hospital outpatient services are the fastest growing segment of Medicare Part B, and this spending growth must be controlled. In addition, as an extension of the policy enacted by the Congress in OBRA 1989, we are recommending that capital payments for outpatient departments be paid at 85 percent of costs for rural hospitals and 75 percent of costs for urban hospitals. No reduction would be made in sole community hospitals.

• *Durable Medical Equipment (DME) Proposals* (Savings of $250 million in 1991)

In order to improve equity in Medicare payment amounts for DME, we are proposing a number of changes, including the following:

—*National Cap on Fee Schedules.* For all fee schedules for DME, prosthetics, and orthotics, we are proposing to limit Medicare payment to the median of the fee schedule amount for each item. In addition, we are proposing to provide a fee update only for items below the limit; fees above the limit would receive no update in 1991. Extremely wide variation exists in fee schedule amounts for DME. If the item can be provided in half the carriers for a fee less than the median, they should be able to be provided in other carriers at the median.

—*Modify Fee Schedule for DME Rental Items.* OBPA 1987 created a new payment system for DME based on fee schedules for six categories of DME. One of the categories covered items such as wheelchairs and hospital beds and provided for payment on a rental basis only. Although the fee schedules for the other five categories of DME were based on average or allowed charges, the fee schedule for this rental category was based on average submitted charges.

We are proposing to change the basis for the fee schedule for the DME rental items to average reasonable charges and thus make this fee schedule consistent with the other five categories of DME.

This proposal would also limit total monthly rental payments for these items to 120 percent of the recognized purchase price (rather than 150 percent under current law). A supplier could receive 10 percent of the recognized purchase price for the first 3 months of rental and 7.5 percent during the following 12 months.

—*Reduce oxygen payments by 5 percent.* OBRA 1987 established a fee schedule for oxygen based on 95 percent of the local average amount reimbursed by Medicare in 1986. We propose to reduce Medicare payment amounts by an additional 5 percent based on evidence that current Medicare reimbursement for oxygen is still unreasonably inflated. The HHS Inspector General examined this issue and found Medicare payment rates for oxygen to be considerably higher than that of other public and private payers.

—*Set fee schedules for enteral products and supplies.* Payment for enteral products is currently consolidated at two Medicare carriers and is the lowest of the actual, customary, or prevailing charge, the lowest charge level or the inflation-indexed charge. Market data show that Medicare payment levels are considerably above available market prices. We propose to establish a fee schedule for enteral nutrients and supplies based on wholesale and retail price information.

• *Clinical Laboratory Services* (Savings of $60 million in FY 1991)

In OBRA 1989, the Congress limited Medicare payments for clinical laboratory services to 93 percent of the median fee schedule amounts. In order to improve equity in Medicare payments for clinical laboratory services, we are proposing to reduce the limit to 90 percent of the median fee schedule amounts for non-profile tests and 80 percent of the median for profile and standardized test packages. We are proposing to provide a fee update only below the limit; fees above the limit would receive no update in 1991. In addition, we are proposing to require independent labs to report the price charged to the ordering physician when that same test is performed for a non-Medicare patient. This information would be used to reduce carrier fee schedules in subsequent years.

• *Competitive Bidding*—As a more long term solution to the issue of determining appropriate Medicare payment levels for durable medical equipment and clinical laboratory services, the Department will be giving serious consideration to conducting competitive bidding demonstrations in FY 1991.

• *Provide Prior Authorization Authority to Carriers* (savings of $64 million in 1991)

We are proposing to extend to Medicare Part B carriers the authority to require prior authorization for medical services and/or equipment. Peer Review Organizations currently have this authority for hospital admissions and certain surgical procedures; however, carriers currently have no effective mechanism to curb the provision of services even when there is strong evidence of a history of over-utilization. Carriers currently have utilization review authority, but they do not have authority to require prior authorization.

• *Extend ESRD Secondary Favor Period* (Savings of $30 million in 1991)

For ESRD-eligible beneficiaries who have employer-sponsored health insurance, we are proposing to extend the period that Medicare is secondary payor beyond the current 12-month period to 18 months. During these additional 6 months, the employer plan would pay full primary benefits.

• *Part B Premium*

The Part B premium rate was originally designed to cover 50 percent of the cost of the Part B program. However, legislation in 1972 limited annual increases to the rate of increase in the Social Security cost-of-living adjustment (COLA). The portion of program costs covered by the premium gradually fell to a low of 24 percent in 1981.

Since 1984 the Congress has set the premium at a level designed to finance 25 percent of the costs of the Part B program. This provision has been extended through 1990, after which the method for setting the premium rate is scheduled to revert to the method in effect prior to 1984.

The FY 1991 budget contains a proposal to set a floor on the rate increase each year, beginning in CY 1991, at the level that would be necessary to finance 25 percent of the program.

Catastrophic Health Insurance (CHI)

Late last year the Congress repealed the Catastrophic Health Insurance portion of Medicare. CHI, which was enacted in 1988, expanded the hospital and skilled nursing facility (SNF) benefits in Part A of Medicare and set a maximum on out-of-pocket expenses in Part B. In addition, it created a new outpatient prescription drug program in Medicare. The Part A benefits were in effect in CY 1989 and the other parts of the program were due to be phased in over the next two years. CHI was to be financed entirely by a combination of tax-related Supplemental premiums and monthly flat premiums.

With the repeal of Catastrophic Health Insurance, those few beneficiaries that paid the supplemental premium in 1989 (by withholding or prepayment) can claim a refund in 1990. The monthly flat premium was collected during 1989 in anticipation of Part B benefits and was deposited in the SMI trust fund. No benefits were paid under the Catastrophic program from the SMI trust fund. Therefore we are proposing that the monthly flat premium revenues now in the SMI trust fund be transferred to the HI trust fund to offset the costs of CHI hospital and SNF benefits paid from that trust fund during 1989.

MATERNAL AND CHILD HEALTH

As part of our continuing effort to improve the health of mothers and children, we are proposing an appropriation of $578.6 million in FY 1991 for the Maternal and Child Health Block Grant program administered by the Health Resources and Services Administration of the Public Health Service. This represents an increase of $25 million over the Fiscal Year 1990 appropriation. We are further proposing that this additional $25 million be used to support a special "one-stop shopping" grant initiative targeted at improving the delivery of health care services to pregnant women and infants. Under this initiative, an estimated 75–100 grants are expected to be made to states or to community-based organizations that can demonstrate adequate plans to alleviate infant mortality problems and provide better access to health care.

SOCIAL SECURITY ADMINISTRATION

OASDI Program

The 1991 budget reflects continued improvement in the financial position of the Federal Old Age, Survivors, and Disability Insurance Trust Funds resulting from implementation of the Social Security Amendments of 1983. This legislation set in place the structure for restoring the financial soundness of the trust funds. I want to acknowledge that Members of this Committee played a major role in shaping the historic 1983 compromise. In view of the success of this agreement, it makes no sense to unravel it.

The 1983 agreement on financing Social Security promised that there will be sufficient funds for benefits today and in the future. Under the 1983 legislation, the cost of the retirement of the "baby-boom" generation would be partially borne by the baby-boomers themselves through the building up of trust fund reserves. The 1991 budget reaffirms that principle. The budget protects the benefits of current beneficiaries while continuing to build reserves that will help finance future Social Security benefits well into the next century.

The President's 1991 budget proposes additional protection for future beneficiaries by setting up a Social Security Integrity and Debt Reduction Fund. The proposal would essentially require that the Treasury annually outlay into a special fund an amount equal to the annual- surplus in the Social Security Trust Funds. That fund would then be used to retire existing debt. The proposal would be phased in by 30

percent in FY 1993 and fully implemented in FY 1994. The proposal would have no effect on Social Security benefits, income, or Trust Fund balances.

Many proposals have been put forth regarding Social Security in recent days. Most have been in the context of budget deficits, but some have dealt with other aspects of Social Security. All of us charged with responsibility for the Social Security programs want to make them work as well as possible, not only for current beneficiaries, but also for those of the future. And we can honestly and with good will disagree about the best way to accomplish our shared goals.

However, there are two issues about which I feel very strongly—Social Security financing and an independent Social Security Administration. In regard to changing Social Security financing, we must use caution before we advance proposals that would retroactively rescind the 1990 Social Security payroll tax increase. I am convinced that the President's proposal provides a comprehensive solution toward accomplishing the dual tasks of protecting the trust funds and retiring a portion of the national debt. In addition, this Administration has made it clear that we are willing to consider other proposals which would protect the trust funds.

I remain firmly opposed to separating SSA from the Department of Health and Human Services. The overriding issue is what kind of administrative structure will help SSA to best serve the public. There is no clear evidence that independence would improve public service—SSA's service is significantly better today than it was a few years ago. The organizational upheaval that would result from independence would divert attention from performance of SSA's basic mission, and this would be wrong from a management standpoint.

Additionally, removal of SSA from HHS would undercut the President's role as manager of the Executive Branch and eliminate many economies of a large government department. Finally, I know that Congress, including members of this Committee, has spent years trying to better integrate the various programs under the HHS umbrella—Social Security, SSI, AFDC, Medicare, Medicaid, etc.—and it would largely defeat these efforts to remove the biggest of these programs from HHS.

Outlays of the Social Security Administration constitute more than 60 percent of total spending by HHS. In 1991, OASDI outlays will increase by $15.7 billion (from $249.4 billion in FY 1990 to $265.0 billion in FY 1991). This increase is accounted for by three factors. The average number of persons receiving Social Security cash benefits—39.4 million retired or disabled workers and their dependents and the survivors of deceased workers this year—is expected to grow by 649,000 beneficiaries in FY 1991. In addition, benefit levels will be somewhat higher, due to higher earnings of newly entitled beneficiaries and the annual cost of living increase, estimated at 3.9 percent payable in January 1991.

This increase in outlays will be more than offset by increased income to the OASDI trust funds. OASDI tax revenues in FY 1991 will reflect the increase in the annual tax base to $51,300 and the increase of 0.28 percent in the combined employee-employer Social Security tax rate that took effect this year. Under current law, Social Security trust fund revenues are expected to exceed expenditures for FY 1991 by more than $80 billion. As of January 1990, the trust funds represented about 75 percent of the year's expenditures and these funds will continue to grow.

OASDI legislative recommendations reflected in the President's FY 1991 budget include new proposals as well as several items that were recommended last year but not enacted. New legislative proposals include the following:

- Extend Social Security coverage to about 3.8 million employees of state or local governments who are not covered by a State or local retirement program. This proposal, which was recommended by the HHS Inspector General in his September 1987 report, would raise income to the Social Security trust funds by $2.3 billion in FY 1991.
- Permit a child who is adopted by the surviving spouse of a deceased worker to receive benefits based on that worker's earnings if the child was either living in the worker's home or receiving one-half support from the worker at the time the worker died. This proposal should make it easier for children adopted after the worker's death to qualify for Social Security benefits.
- Provide authority for the Internal Revenue Service to withhold income tax refunds from former Social Security beneficiaries who have failed to cooperate in repaying their outstanding overpayments. A similar proposal was included in the House-passed reconciliation bill (H.R. 3299) last year. We hope it will be enacted this year.
- Limit reimbursement for the travel of claimants' representatives to the maximum that would be allowed for travel within the geographical area served by the office conducting the hearing (or reconsideration proceeding). This proposal is needed to curb a growing abuse whereby attorneys, many of whom are under con-

tract to large insurance firms, travel great distances to accompany claimants or beneficiaries to a local hearing office. Although the fiscal impact of this proposal is not such that it is separately identified in the budget, we believe it is a significant initiative. A similar proposal was included in the package of Social Security proposals that the Senate Finance Committee forwarded to the Senate Budget Committee in October 1989, but was not included in the "stripped" reconciliation bill last year.

In addition to these new legislative proposals, several unenacted provisions from our FY 1990 package, forwarded to the Congress last June and reflected in our FY 1991 budget, deserve special mention:

- We continue to support the extension of Social Security coverage to certain employees of the District of Columbia—newly hired teachers, judges, policemen and firemen. Newly hired general employees of the D.C. government were covered as of October 1, 1987.
- The budget again reflects the elimination of the so-called "normalized" tax transfers to the Social Security trust funds. This provision, enacted in 1983, is no longer needed and gives rise to significant bookkeeping difficulties.
- The budget also reflects our FY 1990 proposal for modifying the present law requirements for pre-effectuation review of favorable disability determinations by State agencies to enable us to better focus the reviews on decisions that are most likely to be incorrect.

These last two proposals were included in the package of Social Security proposals forwarded by the Senate Finance Committee to the Senate Budget Committee in October, 1989, but was not included in the reconciliation bill last year.)

SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM

Some 4.6 million aged, blind, or disabled persons with low incomes and resources receive Federal SSI payments and/or federally administered State supplementary payments. Nationwide, approximately 2 million of these persons receive federally administered State supplements. The SSI program is the income source of last resort for aged (65 and older) blind, and disabled persons with low incomes. The program provides a national minimum benefit amount for individuals and couples. States may choose to supplement the Federal payment and have these supplements administered by SSA.

The maximum Federal benefit amount, adjusted for the January 1990 COLA, is $386 per month for an individual and $579 per month for a couple. We currently anticipate that this amount will increase to $401 per month for an individual and $601 per month for a couple when payments are adjusted for the estimated 3.9 percent COLA payable in January 1991.

Generally, amounts paid to recipients vary from the standard benefit according to the amount of other income received (e.g., earnings and Social Security benefits) and living arrangements of the recipients (e.g., residence in one's own home, the household of another person, or in a nursing home which meets Medicaid standards)

Benefit payments in the 1991 budget reflect an estimated increase of $1.843 billion over 1990. The 1990 appropriation included 11 monthly benefit payments, compared to 12 monthly payments in FY 1991. Since October 1, 1989 fell on a Sunday, the payment for October was on September 29 and counted against FY 1989—thus the "11 month year" for FY 1990. I would like to bring to your attention a major initiative that the Social Security Administration is undertaking in the SSI program. We have launched a major outreach initiative to ensure that all persons who may be eligible for these benefits, including the homeless, are aware of them and have the opportunity to apply. We are also continuing to pursue initiatives designed to strengthen the potential for disabled persons to work and become self supporting.

The FY 1991 budget includes a legislative proposal that would charge States for Federal administrative services for SSI State supplementary payments.

FAMILY SUPPORT ADMINISTRATION

With the enactment of the Family Support Act of 1988, the Administration and Congress took an important step forward in assisting low-income families become financially independent. The Job Opportunities and Basic Skills Training (JOBS) program is the cornerstone of the Family Support Act of 1988, legislation that the Committee on Finance began crafting in early 1987. The objective of JOBS is to encourage and assist AFDC recipients to acquire the skills and self-confidence they need to become self-supporting. Through the JOBS program, 27 states are providing recipients of Aid to Families with Dependent Children, especially young single

mothers, with enhanced opportunities to participate in education, job training, and work activities. All states are required to implement JOBS by October 1, 1990.

For the Job Opportunities and Basic Skills Training program, the budget provides one billion dollars. This is the maximum amount authorized by law and represents an increase of more than half a billion dollars over the amount we estimate will be spent this year. We also estimate that $489 million in Federal matching funds will be provided for child care services under the Act. This is more than double the amount estimated for 1990 and 28 times the level of child care spending for participants in AFDC work programs in 1989.

I am optimistic about the potential of the JOBS program because it gives States several new tools to help recipients become self-supporting. The Family Support Act allows states to pay for child care costs and other work-related expenses for AFDC recipients who are participating in JOBS activities. In addition, recipients who leave the welfare rolls due to work may receive transitional child care assistance and Medicaid beginning April 1, 1990. Finally, this Department has developed a close working relationship with the Department of Labor, the Department of Education and the Department of the Interior to ensure that our efforts are coordinated. We are encouraging the same type of coordination at the state and local levels to avoid duplication and to maximize the use of all available resources.

Another key focus of the Family Support Act is strengthening of the Child Support Enforcement program. We continue to make good progress in the program as a result of these provisions. Collections on behalf of all families are projected to be $6.8 billion in FY 1991, a 29 percent increase over FY 1989 and a 48 percent increase over FY 1988. These figures reflect aggressive implementation by the states of several key provisions of this Act—primarily immediate wage withholding and the establishment of mandatory support guidelines, as well as the impact of recently promulgated Federal standards for program operations.

Even though we have seen great increases in support collections, some states still are performing poorly and parents are being allowed to shirk their financial responsibilities—often at the expense of the taxpayers. In order to move the Child Support Enforcement program forward at a more rapid pace, we are proposing three legislative changes. These legislative proposals are expected to produce net savings of $10 million in FY 1991, and $150 million over five years (1991–1995). Increased family income from these proposals would decrease benefit costs under other Federal programs by $50 million in FY 1991 and $330 million over five years.

- *Child Support Enforcement Cost Recovery*

First, we are proposing that non-poor families who benefit from child support services help taxpayers pay for the services. States would be required to recover a portion of these costs from both absent and custodial parents based on their respective ability to pay but only after current support obligations are satisfied. Additionally, the current $25 application fee ceiling would be replaced with an income-tested sliding scale fee for non-AFDC individuals. No fees or costs would be charged to individuals with income below 150 percent of the poverty line.

- *Child Support Services for Additional Recipients of Federal Assistance*

Second, we are proposing legislation that would require recipients of assistance in other Federal programs, such as Food Stamps, to cooperate in the establishment of paternity and child support enforcement as a condition of continued receipt of Federal Assistance. The Food Stamp program would be the first program to incorporate this additional requirement with savings for the Department of Agriculture projected at $50 million in FY 91.

- *Increase Efficiency in States' Child Support Enforcement Programs*

Finally, we are proposing to limit the amount of Federal funding for administrative costs for those states that are inadequately pursuing support on behalf of families on welfare. The current financial structure, including incentive payments, has been deficient in altering the behavior of states that perform poorly. Capping the Federal match for administrative costs will stimulate these states to increase collections and to be more efficient.

The proposed legislation would cap the amount of Federal funds available to States for administrative expenses of their support enforcement programs at 100 percent of their support collections on behalf of AFDC families. From FY 1992 through FY 1999 for States that are ineffective, this cap would be progressively lowered to 66 percent of the level of their AFDC collections. Currently, State's CSE administrative costs are matched on an open-ended basis.

A new program is being proposed this year to be administered by Family Support Administration. We will be seeking an amendment to the Social Security Act for a new broad-based cash assistance program to Puerto Rico—called the Fiscal Assistance to Puerto Rico program. This $825 million program will be designed to give the Commonwealth broad flexibility in meeting the needs of its it low-income population.

HUMAN DEVELOPMENT SERVICES

In child welfare services and foster care, the Administration's priorities are clear. We want to prevent unnecessary placement of children outside their families, reunify children with their families, or when that is not possible, find permanent, loving homes for children through adoption.

Our proposals reflect these priorities. First, contingent upon enactment of foster care administrative cost reforms, we are requesting $300 million for Title IV-B Child Welfare Services, including a transfer of $47 million from Title IV-E foster care. This 19 percent increase will provide relief to Child Welfare systems, strained by large numbers of dysfunctional families entering the system, especially those afflicted with substance abuse related problems. These additional funds will provide services to foster and adoptive children, as well as those at risk of being removed from their homes. This increase in funding reaffirms our commitment to prevention, reunification and adoption efforts.

In conjunction with this increase, we are proposing to limit the rate of growth of administrative costs of the Title IV-E Foster Care program to no more than 10 percent per state per year. Between 1981 and 1991, the administrative costs under the Foster Care program will have increased a staggering 2800 percent, from $30 million in 1981 to a projected $882 million in 1991. During the same period, the number of children served increased only 99 percent, and the maintenance payments to support these children increased about 233 percent. Unless we take some action, administrative costs will continue to grow at an unacceptable rate. This proposal will leave maintenance payments to children, as well as training funds for foster care parents and case workers, as entitlements.

In addition, we are requesting $544 million to reimburse states for their prior year claims under the Foster Care program, and we are requesting $38 million in additional monies to fully fund the Social Services Block Grant program. These requests complement our ongoing efforts to emphasize the prevention and reunification services that help to keep families together.

Head Start

Mr. Chairman, although the Finance Committee does not have jurisdiction over the Head Start program, I would like to make a few comments about it. A major expansion of the Head Start program is included in the President's 1991 Budget. Making the Head Start experience available to all eligible children four years old and their families is the foundation for fulfilling President Bush's commitment to give all children an equal start in life. The largest spending increase—a 36 percent increase—in the history of the program will allow up to an additional 180,000 children to enroll in Head Start. By participating in the comprehensive Head Start program, these disadvantaged children will receive the extra help they need to start school ready to learn. President Bush's 1990 Budget, his first budget, began the process for Head Start expansion, calling for an increase of 95,000 additional children. Congress was unable to provide for this full request; however, the President's commitment to expansion of the Head Start program remains strong in the 1991 budget request of $1.9 billion.

PREPARED STATEMENT OF ROBERT T. VAN HOOK

Mr. Chairman and Members of the Senate Finance Committee, my name is Robert T. Van Hook and I am the executive director of the National Rural Health Association (NRHA). I am very pleased to be here today on behalf of the NRHA's diverse national membership.

Last year, Congress included several provisions in the 1989 Reconciliation Act to improve the delivery of health care services to rural Americans, including: (a) a significant increase in the rural hospital update; (b) physician payment reform; (c) expansion of the Rural Health Clinics Act; (d) improvements in Medicare reimbursement for sole community hospitals; and (e) the establishment of the Essential Access Community Hospitals and Rural Primary Care Hospital Programs. Several of the provisions that I just mentioned were originally included in legislation that was in-

troduced by Senators Bentsen and Dole in early 1989 and other parts were spurred by initiatives introduced by other committee members. The entire Senate Finance Committee was instrumental in seeing that these initiatives were enacted, and the committee has traditionally been a very good friend to rural health. On behalf of rural America, thank you

Although significant progress has been made in improving the programs effecting the delivery of rural health care services, more remains to be done. First and most importantly, NRHA opposes significant budget reductions in the Medicare program. Medicare cutbacks would be especially harmful to rural and inner-city hospitals, physicians and ultimately, their patients. The Administration proposes a $5.6 billion reduction in the Medicare program; $3.4 billion would come from Part A payments to hospitals and $2.2 billion would come from Part B. Other Medicare reductions that are proposed in the President's budget include:

(a) a 4.1 percent update for all hospitals with no distinction made between urban and rural. If this update factor is adopted by Congress, the update will fall well below the inflation rate;
(b) a 10 percent cut in outpatient services; and
(c) a 15 percent reduction in hospital capital payments.

NRHA strongly opposes these three proposals for the following reasons:

(a) Update: The hospital update must at least keep pace with inflation, otherwise it becomes a cut in payments. Clearly, rural hospitals, a majority of which are already losing money on Medicare, cannot afford further Medicare cuts. Last year, Congress passed legislation requiring the Secretary of Health and Human Services to develop a plan for eliminating the urban/rural differential in Medicare hospital payments and that plan will be fully implemented by 1995. However, many rural hospitals cannot wait until 1995 for implementation. NRHA believes that Congress should fully eliminate the remaining 7–8 percent urban/rural differential in standardized Medicare hospital payments in FY 91 as called for in Senator Packwood's recently introduced legislation. We urge an immediate elimination of the differential because, according to a recent study performed for NRHA by Lewin Associates, the cost to raise the rural rate up to the small urban rate is only $353 million. NRHA would oppose adjusting standardized rates based on current costs, because chronically low PPS payment rates tend to depress costs over time. The adage, "You can't spend what you don't have" holds true.

Generally speaking, the Prospective Payment System (PPS) does not work well as a payment methodology for the smallest rural hospitals because they do not have the large numbers of cases that are essential for the DRG—based system to properly function. While we have serious concerns about cost-based reimbursement methodologies, NRHA recommends that Congress consider cost-based reimbursement for all rural hospitals under 50 beds. In its second annual report to the Secretary of HHS, the National Advisory Committee stated that hospitals under 50 beds have shown to be the most financially vulnerable under PPS. The report further stated that since these hospitals tend to be low cost providers, the impact on the Medicare budget would be minimal.

(b) Outpatient payments: Hospital outpatient charges are a higher percentage of total charges for rural hospitals than for urbans. Studies indicate that rural hospital outpatient services account for 350 percent of all rural hospital charges compared to 18–22 percent for urban institutions. Additionally, outpatient reimbursement is essential for maintaining access to rural emergency care and other essential services. Recent reductions in Medicare payments, such as for outpatient surgery and laboratory services, have had a disproportionately negative impact on rural hospitals, and the additional 10 percent cut proposed in the President's budget could have a disastrous impact on access to rural health care services. NRHA urges Congress to pay rural hospitals for outpatient services on a reasonable cost basis and to resist any additional reductions in payments for outpatient services.

(c) Hospital capital: Many rural hospitals were constructed during the 1950s and 1960s under the Hill-Burton Program and are in need of renovation. Additionally, without access to capital, rural hospitals may slip in their ability to acquire the technology that modern medicine demands. Medicare pays for approximately 50 percent of patient care in rural hospitals and therefore, accounts for a large percentage of their capital expenses. Capital payments for most rural hospitals is pegged at 85 percent of historical costs. NRHA encourages Congress to increase the percentage of capital cost pass-through for rural hospitals rather than reducing capital payments.

There are additional policy issues that the National Rural Health Association urges the committee to consider including the following:

• Area Wage Index: Although progress has been made regarding the urban/rural differential in Medicare standardized payments, there is another component of the Medicare payment equation that needs to be examined—the area wage index. The area wage index is a considerably larger source of inequity than the standardized DRG payments. NRHA is exploring the National Advisory Committee on Rural Health's recommendation that the Congress should enact legislation that would require the Secretary to implement a refined area wage adjustment that better reflects actual variations in wages for professional and nonprofessional employees. It is my understanding that in September, HCFA will issue refinements for calculating the area wage index. NRHA looks forward to working with this committee, PROPAC, and AHA in devising an area wage index that will be equitable for both urban and rural areas.

• Senator Packwood's Rural Health Improvement Act of 1990 (S. 2214) and Senator Pryor's initiative last year focus on an interesting concept; tax credits for certain primary care providers. Senator Packwood would extend this tax credit to any provider (which is defined as a physician, physician assistant, or nurse practitioner) providing primary health services in a rural area for a period of 5 years. His bill would also exempt National Health Service Corps loan repayments from gross income. NRHA supports this provision of Senator Packwood's bill, as well as several other relevant provisions which I will mention later in this testimony.

• Nurse practitioners are important to the delivery of health care services in rural areas. They are licensed by states to perform medical services that are not performed by traditional nurses. Nurse practitioners are able to provide approximately 80 percent of the services usually provided by primary care physicians. Most states require nurse practitioners to work in collaboration with a physician. For this reason, NRHA supports direct Medicare reimbursement for nurse practitioners. Senator Packwood has included this provision in his proposal and Senator Daschle introduced a bill regarding this concept last year.

• NRHA also supports the establishment of a national uniform fee schedule for Certified Registered Nurse Anesthetists at the annually-adjusted rate of $14 for services under the medical direction of a physician and $21 for services that are not medically directed. This is also included in Senator Packwood's omnibus rural health bill.

• NRHA was very pleased with the critical role that committee members, including Chairman Bentsen and Senators Rockefeller, Durenberger and Mitchell played in passing physician payment reform last year. We are hopeful that this reform will have the intended effects of adequately rewarding doctors for providing high quality primary care services regardless of specialty or geographical location. NRHA would like to see the 5 year implementation process speeded up to two or three years.

• Senator Packwood's bill includes a provision to remove the restriction on payment for physician assistant (PA) services to allow a physician assistant to provide services in a rural area regardless whether the area has received a health manpower shortage area (HMSA) designation. This will appropriately expand incentives for PAs to practice in rural areas.

• NRHA is also supportive of the provision in Senator Packwood's bill that calls for a review of hospital regulations affecting rural hospitals. This is a process that is critically needed at this time. Since the advent of PPS, many regulations have been put into effect without careful consideration of the consequences to rural hospitals. Also, the changing rural health care environment is requiring hospitals to make adaptations that were not relevant when the regulations were adopted. The state of California has recently gone through a similar regulatory review process with very positive results.

There are two additional provisions in Senator Packwood's proposal that this committee does not have jurisdiction over, but which are extremely important to rural health care delivery, including the increased funding (to $25 million) for Area Health Education Centers and authorization of $25 million for preventive health grants to county health departments.

Also, as you know, an adequate supply of health professionals is needed for practice in rural and underserved areas. You can have doctors without hospitals, but you can't very well have hospitals without doctors. We must have a revitalized National Health Service Corps to help us meet the critical needs of rural America. Senator Packwood has made this a major focus of his bill and Senator Daschle introduced a proposal regarding the National Health Service Corps.

The National Rural Health Association truly appreciates the work of this committee in addressing the difficult issues facing rural health care. However further action is needed so that rural Americans, which comprise 25 percent of the population, will continue to have access to high quality health services which are an essen-

tial part of their economies and their quality of life. You have proven in the past that you share this goal. I look forward to working with all of you toward this end.

PREPARED STATEMENT OF BRUCE VLADECK

Good morning Mr. Chairman. My name is Bruce Vladeck and I am a member of the Prospective Payment Assessment Commission and the Chairman of its Subcommittee on Hospital Productivity and Cost-Effectiveness. I am pleased and honored to represent the Commission here today to discuss our recommendations. I am also pleased to be accompanied today by Donald A. Young, M.D., the Commission's Executive Director.

The Commission's most recent recommendations are contained in our sixth annual report to the Secretary of Health and Human Services, which was delivered to the Congress and to the Secretary earlier this month. Dr. Young or I would be happy to answer any question about any aspect of the report, as well as about our statement today. My testimony today briefly highlight our Report, beginning with some background on the financial status of hospitals under PPS, and then describing our principal recommendations for fiscal year 1991.

BACKGROUND

Mr. Chairman, Medicare's prospective payment system (PPS) has been in place now for six years. As you know, PPS was intended to control expenditures by giving hospitals financial incentives to improve efficiency and productivity in the delivery of services to Medicare beneficiaries. And indeed, since the inception of PPS, the rate of increase in the Medicare program's expenditures for inpatient hospital services has moderated. Much of this decline in spending has resulted from decreases in hospital admissions. Still, after adjusting for inflation, Medicare payments per admission have risen more slowly since PPS than before.

At the same time, while hospitals did well financially in the early years of PPS, the more recent experience has been less favorable as a result of the relationship between continued large increases in hospitals' costs and constrained Medicare payments.

In the first year of PPS, perhaps because hospitals anticipated a reduction in revenues, costs per case increased less rapidly than in prior years. Since then, however, the rate of increase in costs per case has returned to previous levels. (EXHIBIT 1 shows these cumulative cost and payment trends graphically.)

The Commission is concerned that hospitals have not continued to control their costs as well as they did in the first year of PPS. One possible reason is that the high margins in the first few years of PPS reduced hospitals' incentives for containing costs. It may also be that hospitals have not significantly influenced their physicians' tendency to use more services, and have instead tried to maintain their financial position by expanding services that generate additional revenue. A possible complicating factor is the large decline in hospital admissions. As admissions decrease, fixed costs must be distributed across fewer cases, thereby increasing per-case costs.

On the revenue side, it's also important to recognize that hospital payments increase both because of annual updates and because of changes in reported case mix across DRGs. As you know, payments automatically increase as the reported mix of patients across DRGs becomes more complex. Since PPS began, the reported case mix has increased dramatically, thereby contributing to the increase in payments. Thus, over the first five years of PPS, payments per case increased about four times faster than the annual update factor.

In the first two years of PPS, payments to urban hospitals increased at a higher rate than payments to rural hospitals, due to faster growth in reported case mix in urban hospitals. Since then, however, that pattern has been reversed. As a result of the higher updates that the Congress enacted for rural hospitals, as well as other statutory changes, payments to rural hospitals have increased at a greater rate than payments to urban hospitals. (EXHIBIT 2 shows changes in payments and costs for urban and rural hospitals.)

While PPS was never intended to directly match payments with costs, there is much to be learned from the Commission's monitoring of hospitals' financial condition under PPS. As an indication of financial condition, we typically look at hospital PPS operating margins—PPS operating revenues in excess of Medicare operating costs. The PPS margin figures we use, it should be noted, exclude both revenues and costs associated with capital and direct medical education, as well as all costs and revenues from non-Medicare patients.

In the early years of PPS, hospitals experienced large PPS margins, because PPS payments were so far in excess of costs. More recently, however, PPS margins have declined. Our latest estimates suggest that average PPS margins fell to zero or below in 1989 and have decreased even further this year. This is because, again, payments have been rising slightly above the rate of inflation, yet costs per case have increased at twice the rate of inflation. Even last year, when PPS payments increased more than 2 percentage points above inflation, margins continued to fall. They will continue to fall unless per-case costs are reduced or Medicare provides substantial additional payments. (EXHIBIT 3 shows PPS operating margins.)

In order to discharge the Commission's responsibilities concerning access to care for Medicare beneficiaries, we also examine hospitals' total margins. The relationship between PPS and total margins has changed substantially since the beginning of PPS. In the first three years of PPS, total margins were roughly half the level of PPS operating margins. In the fourth year, total margins were still below the PPS operating margins, averaging roughly 4 percent. In the fifth year of PPS, and for the first time since PPS began, total margins were higher than the average PPS operating margins. In other words, in the first four years of PPS, net Medicare payments contributed substantially to the financial overall well-being of hospitals. That is no longer the case. (EXHIBIT 3 shows total margins.)

We have also compared margins across hospitals of different types. For each year of PPS, average PPS margins have been lower for rural hospitals than for urban hospitals, although the absolute difference has been narrowing. In the fifth year of PPS, rural hospitals had average PPS margins of minus 3.3 percent while urban hospitals had average PPS margins of 2.7 percent. (EXHIBIT 4 shows urban and rural PPS margins for the fifth year of PPS.) This difference is not found when you examine hospitals' total margins in the fifth year of PPS. Rural hospitals had average total margins of 3.5 percent and urban hospitals had average total margins of 3.4 percent. In addition, in all years of PPS, rural hospitals' average total margins have been positive.

The Commission is very concerned by the considerable variability in margins across hospitals. Data from the fourth year of PPS indicate that almost half of the hospitals incurred losses under PPS, while more than 10 percent had positive margins in excess of 18 percent. We believe that this wide variability of hospital financial performance suggests there are significant areas in which further improvement in the PPS system are required. PPS contains a number of adjustments that are intended to account for variations in costs that are beyond hospitals' control. However, some factors that affect costs cannot be readily measured, and other sources of cost variation may not yet be adequately understood. We need to better understand the sources of the variation in financial performance and the reasons that some hospitals have done so well under PPS while others have not. We have several studies underway to address these issues and we will be recommending changes to you and to the Secretary where appropriate.

With these remarks as background, Mr. Chairman, let me turn now to our specific recommendations for fiscal year 1991.

PPS UPDATE FACTOR

For fiscal year 1991, the Commission recommends an overall average update to the PPS rates of 4.9 percent. This increase is half a percentage point less than the projected rate of inflation for PPS hospitals. Within the overall update, we are recommending different updates to the urban and rural standardized amounts—4.5 percent for urban hospitals, and 7.0 percent for rural hospitals.

In developing its update recommendation, the Commission used the same general framework that it has used over the past six years. Exhibit 5 shows each of the factors that were considered in developing this recommendation.

The first component is the hospital market basket, which measures hospital price inflation. It is forecast to increase 5.4 percent for fiscal year 1991. This year, as we did last year, we are also recommending technical changes in the structure of the market basket to improve its validity and reliability by giving more weight to hospital industry wages and contract labor expenses.

The second element of the update factor is the cost to hospitals of keeping up with scientific and technological advances. At the same time, the statute requires us to also consider how much hospitals should be expected to increase their productivity over the next year. Our recommendation reflects the Commission's belief that the costs of scientific and technological advancement can be funded by productivity improvements within each hospital. Therefore, the allowance for scientific and technological advancement was offset against the allowance for productivity improvement.

As I noted earlier, the total change in the case-mix index has been a larger source of PPS revenue increases than the annual payment updates and all other payment policy changes combined. This year we are recommending an adjustment of a minus 0.5 percent to account for the extra revenues that hospitals received last year from reported case-mix increases that were not due to treating sicker patients.

As you can see on the table showing the update framework (EXHIBIT 5), the resultant overall update recommendation is 4.9 percent. This 4.9 percent increase reflects the Commission's judgment about the appropriate increase in the overall level of PPS rates for fiscal year 1991.

We are also recommending phasing out the differential between the rural and "other" urban standardized amounts over three years. We recommend the three-year phase-out rather than the five years suggested by the Congress because new evidence suggests that urban hospitals' payments, relative to their costs, are higher than those for rural hospitals. This is primarily because urban hospitals have had a much larger increase in payments from reported case-mix index change than rural hospitals.

In keeping with its previous recommendations, the Commission proposes phasing out the difference between the other urban and rural standardized amounts. The preferred approach is to accomplish this through adjustments to the update factor. This approach will incrementally increase the rural standardized amount up to the level of the other urban standardized amount, without increasing or decreasing total Medicare payments to hospitals.

Therefore, as a result of the additional adjustments to the standardized amounts, our update factor recommendation includes a 2.1 percent adjustment for rural hospitals. So as to make this adjustment in a budget neutral fashion, the adjustment for urban hospitals is a minus 0.4 percent.

The standardized amount for hospitals in urban areas with more than one million people is greater than the standardized amount for hospitals in other urban areas. Our analysis shows that the costs of hospitals in large urban areas, while somewhat higher than those for hospitals in other urban areas, are not of a magnitude that would warrant a further widening of the payment differential. Therefore, we are recommending that the current difference between the two urban standardized amounts be maintained, and that no additional adjustment for hospitals in large urban areas be made this year.

The Commission also recognizes that the financial environment in which hospitals in this country are operating is changing rapidly. We can only estimate the impact of the most recent changes in PPS payment policy. Therefore, the Commission will continue to closely monitor the relative financial condition of large urban, other urban, and rural hospitals. We will also continue to analyze the relationship between their costs and payments and reassess this and other refinements that we have recommended.

Finally, Mr. Chairman, the update factor is only one source of growth in PPS payments to hospitals. As I have mentioned, hospitals automatically receive higher payments for increases in reported case mix. In fiscal year 1991, we estimate that hospitals will, on average, receive a 2.5 percent increase in payments from the estimated change in their case-mix index. Together with the 4.9 percent update, the average increase in per-case PPS payments will thus be about 7.4 percent in fiscal year 1991. Most of this increase in payments attributable to case-mix index change will go to urban hospitals if past experience is maintained. (See EXHIBIT 6)

EXCLUDED HOSPITAL UPDATE FACTORS

Each year the Commission recommends an update factor for hospitals and units that are excluded from PPS. These hospitals use a different mix of resources than PPS hospitals. Further, their payments are not based on DRGs and thus, they do not have a case-mix index. Therefore, the update factor for excluded hospitals is determined separately from the PPS update factor. We are recommending that the target rate of increase for rehabilitation and psychiatric facilities, and long-term hospitals should be 5.6 percent for fiscal year 1991, an amount equal to the projected increase in the PPS-exempt market basket. Children's hospitals should receive an update equal to the projected increase in the PPS market basket, 5.4 percent.

We believe that a review of the impact and effectiveness of the target rate limits for excluded hospitals is necessary. We are currently examining changes in operating costs, TEFRA target payments, and gains or losses per discharge. In addition, we are examining whether the characteristics and resource use of patients treated in PPS-excluded facilities have changed since 1983. These analyses will provide some insight into whether hospitals' target rates should be rebased using more recent data. We had hoped to have this analysis completed by now, but we have encoun-

tered some problems with the data. We will keep you informed as this work progresses.

INDIRECT MEDICAL EDUCATION ADJUSTMENT

In formulating its recommendations for fiscal year 1991, the Commission spent more time on the indirect medical education adjustment than any other issue. As you know, hospitals with medical education programs have higher costs than other hospitals. PPS recognizes these higher costs with a payment adjustment based on the ratio of the number of interns and residents to the number of beds. Currently the adjustment is 7.7 percent for every one tenth percent increase in the ratio of interns and residents to beds. Since the beginning of PPS, policymakers have been concerned with the appropriate level of this adjustment.

In our analysis, we calculated the extent to which teaching hospitals, in the most recent year for which data were available, had higher costs than other hospitals. To separate the effects of teaching activity from other factors, the analysis controls for the effects of case mix, wage differences, disproportionate share status and other factors that PPS already recognizes. Our analysis suggests that for every 0.1 percent increase in the ratio of interns and residents to beds, costs in teaching hospitals increase 3.2 percent, in contrast to the current adjustment of 7.7 percent.

We also examined how well teaching hospitals were doing financially in caring for their Medicare patients, as well as in the aggregate. That analysis showed that major teaching hospitals had average PPS margins of 11 percent in the fifth year of PPS. We also found, however, that major teaching hospitals were doing much more poorly overall. Total margins for major teaching hospitals were minus 0.7 percent. (See EXHIBIT 4)

We cannot claim to totally understand why teaching hospitals are doing so well under Medicare and so poorly overall. However, the special role many of these hospitals play in carrying for the medically indigent, in a period when the number of the uninsured and underinsured has grown and many states have tightly constricted Medicaid reimbursement, obviously plays a major part. The Commission believes that Medicare has a responsibility for the health care system as a whole, if for no other reason than to ensure continuing access to services for Medicare beneficiaries. We also believe that the problems of access to care for the medically indigent need to be addressed by public policy.

Reducing the indirect medical education adjustment to 3.2 percent might seriously jeopardize the financial position of many teaching hospitals, impair their ability to fulfill their unique mission, and threaten the quality of care they can provide.

Our recommendation reflects these concerns by asking that the reduction of the teaching adjustment be much less than would be warranted by our statistical analysis. For fiscal year 1991, ProPAC proposes that the level of the indirect medical education adjustment be reduced from 7.7 percent to 6.8 percent. We further recommend returning the savings to the standardized amounts for all hospitals. This would increase urban standardized amounts by an additional 0.6 percent above the level of the update factor and reduce payments to teaching hospitals by 2 percent. (See EXHIBIT 7)

Further reductions in the indirect medical education adjustment should only be made, the Commission believes, after more updated data are analyzed and the financial condition of teaching hospitals further explored.

ACCESS TO CARE IN RURAL AREAS

Mr. Chairman, earlier in my testimony I detailed a number of differences in the performance of urban and rural hospitals since the beginning of PPS. The Commission has long shared this Committee's concern about access to care for beneficiaries living in rural areas, and we have studied this issue from a number of perspectives, some of which we want to report to you today.

One of the major problems faced by rural hospitals has been a decline in admissions. Total admissions to rural hospitals decreased an average of about 5 percent annually between 1980 and 1987. In contrast, admissions to urban hospitals decreased an average of only 0.4 percent annually over the same time.

This decline in admissions to rural hospitals led us to examine the rates of hospital admissions for Medicare beneficiaries living in rural areas. We found that while the rate of admissions to rural hospitals was declining, rural residents had a higher rate of overall hospital admissions than urban residents in the five states we studied. This pattern of higher rates of inpatient hospital use by rural residents has existed for some time. Over the period we studied, however, the difference in hospital use for urban and rural residents narrowed only somewhat. Our study also found

that residents of rural areas go to urban hospitals to receive more technologically complex medical care. Rural residents continue to go to rural hospitals for services that are less complex and for which there is general agreement about the need for hospital care. In short, our data do not yet show any serious deterioration in rural beneficiaries' access to hospital care, in general, although there are clearly some specific instances where problems have occurred.

We plan to continue this work. We believe that it is important to look not only at the patterns of use of rural hospitals, but at the patterns of overall hospital use by rural residents. We are aware, however, that examining only the rates of hospital use is not enough. There may be factors related to the availability of other services in rural areas that influence hospital admission rates, and we plan to examine this broader topic as well.

CONCLUSION

In its early years, hospitals did well under PPS. More recently, hospitals have faced increasing financial pressures. Thus, PPS may only now be reaching the point where its impact is strongly felt.

As the financial pressures of PPS continue, we will review the system carefully to ensure an adequate level of payments and an equitable distribution of those payments among hospitals. The wide variability of hospital financial performance under PPS suggests that the current set of payment adjustments may fail to capture some key sources of cost variation. Therefore, we are expanding our studies to examine why some hospitals are doing well under PPS and others are not.

Mr. Chairman, I appreciate the opportunity to discuss with you our most recent report and recommendations. I will be glad to provide further information on any of these topics, or answer questions you or members of the Committee may have. We look forward to maintaining our close working relationship with you and your staff.

Thank you very much.

Enclosure.

EXHIBIT 1

Cumulative PPS Cost and Payment Trends
Percent Change First Five Years

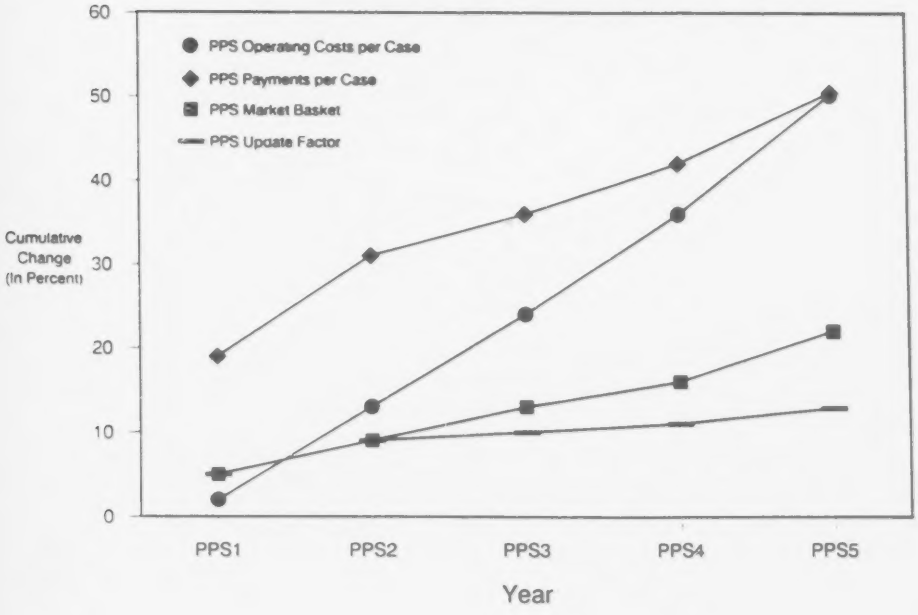


EXHIBIT 2

Percent Change in PPS Operating Costs per Case During First Five Years of PPS, by Hospital Group

Hospital Group	TEFRA to PPS 1	PPS 1 to PPS 2	PPS 2 to PPS 3	PPS 3 to PPS 4	PPS 4 to PPS 5	Average Annual Change
All hospitals	2.1%	10.4%	9.8%	9.8%	10.6%	8.5%
Urban	2.0	10.3	9.4	9.9	10.4	8.4
Rural	1.6	9.1	10.0	8.3	11.5	8.0

Note: Excludes hospitals in Maryland and New Jersey; hospitals in Massachusetts and New York included beginning with PPS 3.

SOURCE: ProPAC estimates using Medicare Cost Report data from the Health Care Financing Administration.

Percent Change in PPS Payments per Case During First Five Years of PPS, by Hospital Group

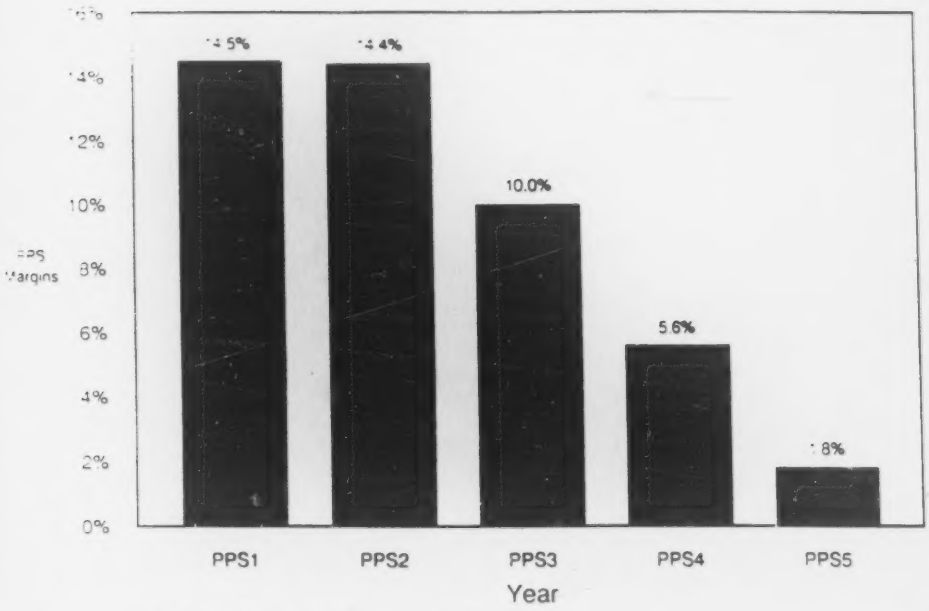
Hospital Group	TEFRA to PPS 1	PPS 1 to PPS 2	PPS 2 to PPS 3	PPS 3 to PPS 4	PPS 4 to PPS 5	Average Annual Change
All hospitals	18.9%	10.3%	3.4%	4.5%	6.3%	8.5%
Urban	20.4	10.1	3.1	4.3	5.8	8.6
Rural	11.4	9.3	3.3	4.4	8.3	7.3

Note: Excludes hospitals in Maryland and New Jersey; hospitals in Massachusetts and New York included beginning with PPS 3.

SOURCE: ProPAC estimates using Medicare Cost Report data from the Health Care Financing Administration.

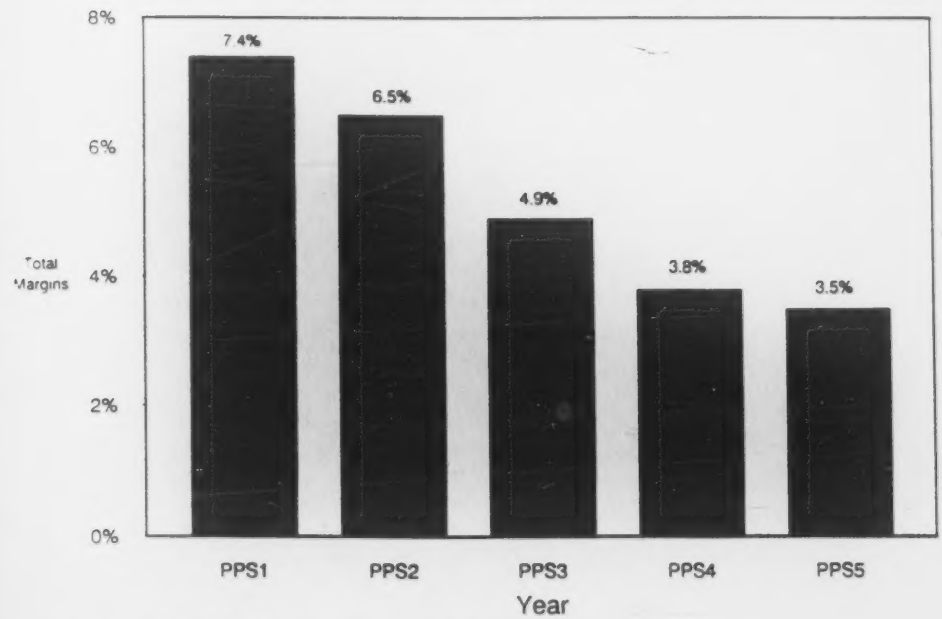
EXHIBIT 3

PPS Margins in the First Five Years of PPS



NOTE: Margins in PPS5 are projected from available PPS5 cost report data.

Total Margins for PPS Hospitals in the First Five Years of PPS



NOTE: Margins in PPS5 are projected from available PPS5 cost report data.

EXHIBIT 4

PPS and Total Margins for PPS Hospitals in the Fifth Year of PPS, by Hospital Group--Preliminary Data

Hospital Group	PPS Operating Margin	Total Margin
All Hospitals	1.8%	3.5%
Urban	2.7	3.4
Rural	-3.3	3.5
MSA >1 million	1.9	2.4
Other urban	3.8	4.8
Rural referral	-0.2	7.4
Sole Community	-4.3	0.8
Other rural	-5.0	2.6
Urban >100 beds	-3.0	1.3
Urban 100-199 beds	0.2	3.2
Urban 200-299 beds	1.6	2.8
Urban 300-399 beds	0.8	4.0
Urban 400+ beds	6.0	3.8
Rural <50 beds	-5.7	1.7
Rural 50-99	-4.5	2.9
Rural 100-149	-4.1	3.5
Rural 150-199	0.3	4.5
Rural 200+ beds	-1.8	5.3
Major teaching	11.3	-0.7
Other teaching	3.1	4.4
Non-teaching	-2.0	4.1
Disproportionate share:		
MSA >1 million	6.9	0.5
Other urban	6.3	5.0
Rural	0.1	3.2
Non-disproportionate share	-1.2	4.0
Voluntary	2.4	3.4
Proprietary	-2.2	5.3
Urban government	5.4	2.1
Rural government	-4.1	2.3

Note: Margins in PPS6 are projected from available PPS5 cost report data.

SOURCE: ProPAC analysis of Medicare Cost Report Files from the Health Care Financing Administration.

EXHIBIT 5

Estimated PPS Update Factors for Fiscal Year 1991 Under ProPAC Recommendations

Components of the Update Factor		
Components applied to all hospitals:		
Fiscal year 1991 market basket forecast[a]		5.4%
Correction for fiscal year 1989 forecast error		0.0
Components of discretionary adjustment factor		
Scientific and technological advancement[b]	--	
Productivity[b]	--	
Total discretionary adjustment factor		0.0
Adjustments for case-mix change		
Total DRG case-mix index change	2.7	
Real DRG case-mix index change	- 1.5	
Within-DRG case complexity change	- 0.7	
Net adjustment for case-mix change		- 0.5
Average update before additional adjustments		4.9
Additional adjustments to the standardized amounts:		
Adjustment for large urban areas	- 0.4	
Adjustment for other urban areas	- 0.4	
Adjustment for rural areas	2.1	
Total Update Factor		
Average update factor		4.9
Large urban	4.5	
Other urban	4.5	
Rural	7.0	

[a] Forecast of ProPAC-recommended PPS market basket by Health Care Financing Administration, Office of the Actuary, February 1990.

[b] In the Commission's judgment, the added costs for scientific and technological advancement can be funded by increases in hospital productivity. Therefore, these components of the update factor sum to zero.

EXHIBIT 6

Estimated Fiscal Year 1991 Average Increase in Per-Case PPS Payments Under ProPAC Recommendations

PPS update factor	4.9%
Estimated case-mix index change	2.5
Total increase in average PPS payments*	7.4

* Most of the increase in payments resulting from case-mix index change will be offset by the increased costs of treating sicker patients.

EXHIBIT 7

Percent Change from FY 1990 Per-Case Payments Under Two Alternative IME Adjustments

	6.8% w/ Program Savings	6.8% Budget Neutral
All Hospitals	-0.6	0.0
MSA > 1 million	-0.8	-0.2
Other Urban	-0.4	0.2
Sole Community	*	*
Rural Referal	-0.2	0.4
Sole/Referral	*	*
Other Rural	*	*
Major Teaching	-2.1	-1.5
Other Teaching	-0.6	*
Non-Teaching	0.0	0.5
Teach/DSH		
NoTeach/NoDSH	0.0	0.5
NoTeach/DSH	0.0	0.6
Teach/NoDSH	-0.8	-0.2
Teach/DSH	-1.3	-0.7

* Less than 0.01 percent.

SOURCE: ProPAC estimates based on data from the U.S. Department of Health and Human Services, Health Care Financing Administration.

RESPONSES TO QUESTIONS FROM SENATOR BENTSEN

Question. We are currently paying for hospital capital under Medicare at 85% of costs. The administration proposes continuing the 15% reduction for rural hospitals, and applying a 25% reduction to urban hospitals. Other proposals would link the level of capital payment to the hospital's occupancy rate (now averaging 65%). ProPAC did a report on occupancy adjustments for capital a year or two ago, and you did not find this approach desirable. Could you tell us the commission's findings and views on this issue?

More generally, what are ProPAC's views on the addition of capital into the prospective payment system? (Scheduled to begin in fiscal year 1992) this has been a very controversial issue. Are you planning to develop new information and recommendations in the coming year?

Answer. The Commission is currently considering capital payment policy again, including consideration of a whole range of options. While we have not yet formed a consensus around recommendations, my personal view is that the Commission is very unlikely to again recommend incorporating all capital payments into the prospective payment system. My personal view, again is that the capital costs of equipment might appropriately be incorporated into PPS, but that the practical and policy difficulties entailed by incorporating physical plant capital are overwhelming.

In April 1988, the Commission indeed recommended against linking capital payment to occupancy rates, for both technical and policy reasons. From a policy perspective, PPS was meant to encourage reductions in lengths of stay, which reduce occupancy rates. Further, flat per-case prices under PPS already provide major financial penalties for hospitals whose occupancy rates are falling due to reductions in admissions. Finally, the hospitals with the lowest occupancy rates tend to be smaller rural hospitals with low capital costs. Reducing their capital payments would not, therefore, produce significant savings for the Medicare program.

Question. Dr. Vladeck, ProPAC has reported that Medicare payments for hospital *Outpatient* services rose from about $2 billion in 1980 to about $7 billion in 1988, a 350% increase. While for inpatient services, we pay hospitals under a *Prospectively* fixed rate, outpatient services are subject to a variety of payment methods depending on the service. These include a fee schedule for lab services and ambulatory surgery payments that blend the hospital's costs with rates paid to freestanding ambulatory surgery centers. About 20% of Medicare payments for outpatient hospital services are paid purely on the basis of hospital costs.

The administration has proposed a 10% across the board cut in hospital outpatient payments for 1991. Do you think this is justified?

The department of HHS is required, with input from ProPAC, by the beginning of next year to develop a proposal for a model prospective payment system for hospital outpatient services. Last year, ProPAC made some recommendations on outpatient surgery. The administration opposed these changes, arguing that we should wait for more comprehensive reform. Are you optimistic that a comprehensive outpatient payment system can be developed anytime soon from what is now a very fragmented set of payment methods?

Answer. We are, indeed, working to develop recommendations by March 1991 for a comprehensive outpatient payment policy, but existing policy is so Complicated, and the range of outpatient services covered by Medicare is so diverse, that producing a coherent policy is likely to be very difficult.

We will be submitting a report to you in July examining increases in spending for hospital outpatient services, and exploring the cost differences between hospital outpatient departments and other services. While ProPAC has not formally considered the Administration's budget proposal for outpatient services, nothing we have learned to date provides, it seems to me personally, any rationale for the kind of across-the-board reduction being proposed.

Question. The administration is proposing cuts in Medicare payments to hospitals which CBO totals at $3.9 billion. These include $590 million in savings from an update factor of market basket minus 1.5 percent, which is a full percentage point lower than the one ProPAC has recommended; $1.2 billion in cuts to teaching hospitals, $1.5 billion from cuts in capital payments and $570 million by reducing outpatient payments.

We all recognized when we started the prospective payment system that hospitals had previously had few incentives to be cost-conscious, that there was some fat in the system. If we were to enact the administration proposals, what do you think hospitals would do in response? Would they cut back on specialized services, such as trauma care? Reduce the number of nurses? Do you think there's room for reduc-

tions this large? Which of the proposals do you think have the most merit from a policy point of view?

Answer. In developing its recommendations for FY 91, ProPAC struggled with the need to balance continuing pressure on hospitals to contain costs with the inflationary pressures hospitals face and the data on hospital performance in the first five years of PPS. Obviously, we believe we struck an appropriate balance, and thus, that the Administration's proposal would be too severe.

Should the Administration's proposals be adopted, the effect on many hospitals would be quite severe. It's difficult to generalize, because the financial performance of hospitals under PPS is so variable, but those hospitals already experiencing highly negative Medicare margins would obviously need to significantly reduce staffing, reduce services, or close altogether.

Question. Dr. Vladeck, ProPAC recently reported that although rural hospitals have experienced a sharp decline in admissions—about 5% a year—residents of rural areas use hospital services about as much as people in cities. While they use the local hospital for basic care, they travel to urban areas to get more high-tech treatment.

Now, there have been interpretations of this study suggesting that we don't need to worry about rural hospitals closing because folks are already traveling farther to get care. Isn't this stretching the results? It seems to me that while those of us who have been working over the years to address problems of rural hospitals are concerned about the number of closures we have had—ten rural hospitals closed in Texas last year alone—our biggest concern is about the precarious condition of those that are left. Does your study address the issue of whether these hospitals are needed? Should rural residents have to travel to the city to get basic hospital care?

Answer. The Commission continues to share your concerns regarding the problems of rural hospitals. The study findings should not be interpreted as indicating that the problems facing rural hospitals have been solved. Nor should the findings be used to infer that rural hospitals are unnecessary. This study addressed hospital use from the perspective of the patient, not the hospital. As you point out, the study found that Medicare beneficiaries who live in rural areas receive care from their local rural hospital for less complex problems, and from referral centers or urban hospitals for more technology-intensive services. Further, the study covered the period from 1984 to 1986. Much has happened since then, and it is important to update this information and continue to closely examine and ensure that rural residents have access to the high quality services they require.

I agree that these hospitals should provide the basic hospital care needs for rural residents. It is also important, however, to ensure that rural residents have access to new, complex, and specialized care that can only be provided by referral hospitals. Our study indicated that is also occurring.

Question. CBO tells us that every percentage point increase we give rural hospitals costs about $60 million, and that eliminating the differential entirely costs almost $400 million. Should we be concerned about taking this money from the urban hospitals? Or is the commission satisfied that a three-year phase in will sufficiently mitigate the effects?

Answer. In developing its update factor recommendation, the Commission carefully considered the impact on urban as well as rural hospitals. We believe that this recommendation, including the adjustment to eliminate the differential between the rural and other urban standardized amounts, is a tough but fair recommendation. As you point out, the three year phase in will lessen the impact. It will also give us the opportunity to assess the impact each year and recommend further adjustments if necessary. This will be especially important as improvements are made in the wage index and the DRG classification systems. As we note in our March report, the effects will also be reduced because urban hospitals will receive larger increases in per-case payments than rural hospitals because we expect they will experience greater increases in reported case mix.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

Mr. Chairman, Members of the Committee, thank you for the opportunity to express certain views on the President's budget proposals for Fiscal Year 1991. I am Byron C. Pevehouse, M.D., a practicing neurosurgeon from San Francisco, California and Past President of the American Association of Neurological Surgeons. I am here representing over 3,000 members of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS).

In a general sense, we are deeply concerned about the differing signals and indeed contradictions between the President's FY 91 recommendations and the policies contained in the Omnibus Reconciliation Act of 1989 (OBRA) and previous years. The neurosurgery community accepted the 1989 OBRA reforms with some exceptions which I will address later. We have cooperated in good faith with the Hsiao RBRVS research. We have developed a working relationship with the Physician Payment Review Commission (PPRC) and are prepared to be full partners when they convene specialty-specific and cross-specialty panels to refine the Hsiao research. We have worked closely with the PPRC on the global fee schedule. We have taken the initiative and are developing practice parameters. We will cooperate with the Health Care Financing Administration in the formulation of surgical volume performance standards. Now we see in the Administration's proposal a disregard for this ongoing process. Little wonder that many physicians are rightfully concerned and skeptical.

OVER PRICED PROCEDURES

When the PPRC first submitted "over priced" lists to the Congress, we challenged the data base and the methodology used to assemble the lists. We continue to question the validity of certain of the PPRC assumptions, however the AANS and the CNS do accept the basic concept of reductions for certain procedures. We do not agree with the administration's proposal for an acceleration of the fee reductions for over priced procedures. This recommendation was made to the Congress notwithstanding that the Hsiao group has not completed its work on the second phase of their RBRVS surveys. Thus there is an absence of reliable data to estimate individual values for surgical procedures—much less justify a mid-stream change. We believe there is a basic fundamental responsibility to keep faith with the surgical community on this emotionally charged issue. Therefore, we recommend that the Committee reject this proposal pending the completion of the physician payment reform package.

REDUCTIONS IN PREVAILING CHARGES FOR NEW PHYSICIANS

The Administration extends to four years the reduction in the payments to new physicians established by the Congress in OBRA 87 and OBRA 89. This proposal is at best arbitrary—why not the fifth, sixth or seventh year of practice. This Committee may not be aware that the Medicare carriers are not implementing this in a uniform manner. It is our understanding that new physicians *entering into solo practice* are being limited to 80 percent of the prevailing charge because of technical difficulties in identifying charges by new physicians who join existing groups. It is patently unfair and inequitable to single out the physician who has just completed residency training and chooses to establish a solo practice. Usually the physician has large debts existing from medical school and postgraduate training and now is assuming a new debt to start up a practice. Why subject him to an 80 percent limitation while the counterpart "new physician" who joins a physician already in prac-

tice or a large medical group, clinic, or medical school faculty is not subject to such a limitation?

Congress, for purposes of equality, should repeal the entire section on limitation of charges for new physicians until the Medicare carriers can identify the charges of *all* new physicians in a uniform fashion.

ASSISTANTS AT SURGERY

The complexity of most major neurosurgical operations requires a fully qualified assistant surgeon. Technical aspects include assisting in careful positioning of the patient, performing various preparatory steps of insertion of catheters and monitoring lines, protection of pressure points, surgical draping of the patient, and then manipulation of various instruments during surgery such as fluid irrigation tips, suction tips, bipolar hemostatic forceps, gentle and flexible use of retractors on nervous tissue. All are done concurrently with the use by the primary surgeon of the neurosurgical instruments to perform the actual surgical procedure.

The use of a fully-trained neurosurgeon as an assistant surgeon has evolved over the years throughout the United States to achieve the highest quality of care and outcome for the patient undergoing a neurosurgical procedure. The two surgeons working together reduce the overall time required for the procedure, lower the risk of complications, and reduce the cost for anesthesia and the operating room, both of which are charged on a basis of time.

All historical charge data and the OBRA 89 legislation to construct a Resource Based Relative Value Scale (RBRVS) for the "global surgical fee" concept have been predicated on payment just to the principal surgeon. All details of the work of the PPRC for preoperative, intra-operative and post-operative care for a surgical procedure have been based only on the fee for the principal surgeon. To obtain qualified assistant surgeons and pay a reasonable fee for the required skill, it has been necessary to pay 20–25% of the fee of the principal surgeon. This methodology has evolved over many years and has been accepted and found satisfactory by surgeons, patients, private sector insurance companies, and governmental agencies. To propose now that the surgeon split the surgical fee with another surgeon will be disruptive to surgical care with unpredictable and potentially negative results.

We do not believe that you would propose that pilots of our commercial airplanes pay for co-pilots out of their own salary to dispense with the use of a co-pilot as a cost-saving measure. This analogy is very similar to what the President is proposing for the surgeons of this country.

In this regard, we subscribe to the suggestion presented to the Senate Finance Committee by the PPRC.

> The Commission plans to explore two alternatives to the Administration's proposal. First, lists of surgical procedures could be developed for which no payment would be made for assistants at surgery. These could be developed by reference to data on incidence of use of assistants at various geographic locations. For each CPT code in which assistants are seldom used at a substantial number of nonteaching hospitals, Medicare would not pay for any assistants. The second alternative would have hospitals pay for assistants at surgery. The primary surgeon would negotiate with the hospital as to whether an M.D. assistant or an operating room nurse should be provided for an operation, either of which would be paid by the hospital. Medicare payments to hospitals under the Prospective Payment System would have to be increased slightly to cover these costs.

We suggest that you direct the PPRC to undertake these studies with a short reporting time . . . perhaps six months.

REDUCE GLOBAL FEE

The global fee schedule will be completed in about 12 months, or in eight months from an estimated time that the Congress will complete a budget. This process is in its critical final stages of calibrating values and we see no reason to act prior to that time.

CONCLUSION

In conclusion, this Committee has worked closely with organized medicine in the development of the RBRVS (American Medical Association) and the Medicare Volume Performance Standards (American College of Surgeons). This is not the time—the eleventh hour of the reform process—to impose on the surgeons of this country arbitrary budget reductions that ignore quality, equity and access.

Members of the Committee, we find the president's budget proposals contradictory and harmful to the orderly process of physician payment changes enacted by the Congress in various reconciliation bills. This is not the time to break faith with the surgical community. *We therefore urge you to reject the Administration's Part B budget plan.*

We recognize the need for budget cuts to comply with the Gramm-Rudman-Hollings Act. *We propose as an interim measure you enact an across-the-board reduction in physician fees; thus allowing the payment reform programs to go forward as enacted by the Congress.*

Thank you.

Statement of the American Clinical Laboratory Association

A. INTRODUCTION

The American Clinical Laboratory Association (ACLA), an organization of federally regulated independent clinical laboratories, appreciates this opportunity to comment on the Administration's Fiscal Year 1991 budget proposals for Medicare reimbursement of clinical laboratories. This Committee faces the difficult task of determining where and how Medicare cuts should be made, and ACLA wishes to offer its assistance this year as it has in past years.

ACLA must emphasize, however, that independent laboratories have suffered substantial reimbursement reductions in each of the past six years. In the laboratory industry, as in health care generally, quality requires the expenditure of substantial funds. Ensuring that beneficiaries continue to have adequate access to high-quality care costs money. At a time when laboratories face increasing costs stemming from changes in the health care environment, the need to meet the highest quality standards and new regulatory requirements, the basic fact is that laboratories cannot continue to absorb significant cuts in reimbursement without some effect on either quality or access to services.

The Administration's FY '91 budget package proposes wide-ranging changes to Medicare's reimbursement of laboratory testing that threaten to seriously undermine the industry's ability to provide high-quality testing services. ACLA has reviewed the proposal and has identified several parts of it which the Association will not oppose. However, other portions of the proposal could make it impossible for many laboratories to survive and could impair quality and access.

In this statement, ACLA first reviews the impact of recent laboratory reimbursement reductions. Against this background, ACLA then discusses its position on the Administration's FY '91 laboratory proposals. Finally, the Association presents its own proposal, which it urges the Committee to consider as an alternative to the package advanced by the Administration.

B. THE CURRENT STATE OF LABORATORY REIMBURSEMENT

Since 1984, when Congress instituted the current laboratory fee schedule methodology, laboratories have suffered eight cuts in payment rates and two freezes in reimbursement levels.[1] ACLA learned recently of an independent consulting firm survey of Medicare reimbursement rates for laboratories in the state of Oregon.[2] The firm found a dramatic drop in Medicare's payment levels. Set out below are the survey's findings, with 1990 rates expressed as a percentage of 1984 (pre-Medicare fee schedule) rates.

CPT–4 Code	Test Description	1990 payment as a percent of 1984 base
80012	12 test screen	66
80032	2 drugs measured	40
81000	Urinalysis with microscopic	57

[1] This analysis excludes the additional effects of Gramm-Rudman-Hollings sequestration.

[2] The survey was not undertaken for ACLA or any of its members. It should be noted that Oregon is not unusual. ACLA members believe that the effects of payment cuts in Oregon have been experienced in most other states as well. ACLA is currently studying this issue to test whether its hypothesis is correct. It will provide the Committee with the results of its analysis.

—Continued

CPT–4 Code	Test Description	1990 payment as a percent of 1984 base
82465	Cholesterol	52
82947	Glucose	34
85022	Automated hemogram with manual differential	53
85027	Automated hemogram with platelets	38
87045	Stool culture	36
87186	MIC sensitivity	32
	Average	45

At least in one state, Medicare is now reimbursing laboratories less than half of what it paid in 1984, before the fee schedules were implemented. For one test, laboratories are receiving only one-third of the amount that they were paid in 1984.[3] When the effects of inflation or Gramm-Rudman-Hollings sequestration are included, these figures are even lower.

Obviously, few industries can suffer such cutbacks without some effect. However, the impact of these rollbacks is even greater since during this same period, most items, and certainly most health care commodities and services, have increased in cost. For example, between 1984 and 989, the Consumer Price Index (CPI) rose by over 19 percent,[4] while the index for all medical services rose by approximately 40 percent.[5] Indeed, between 1988 and 1989 alone, the cost of outpatient services alone rose by over 10 percent.[6]

Moreover, laboratories have been faced with a number of specific increases in expenses over the last several years. The emergence of AIDS, for example, has caused laboratories to spend growing amounts on safety precautions to protect laboratory workers. New regulations to be issued by the Occupational Safety and Health Review Commission (OSHRC) that require laboratories to take additional precautions to protect workers will add to these costs. Obviously, laboratories understand the necessity of protecting their workers from AIDS and Hepatitis B; however, implementing these precautions is expensive.

In addition, comprehensive quality assurance regulations recently issued pursuant to Medicare and the Clinical Laboratory Improvement Act of 1967 (CLIA'67), which are scheduled to go into effect later this year, will require most independent clinical laboratories to spend increasing amounts on regulatory compliance. Other regulations implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA'88), which are scheduled to be issued in proposed form in the near future, will, when effective, require further expenditures. These cost escalations are, of course, in addition to the rising wages and other expenses that laboratories, like other businesses, experience.

Finally, when compared with other Medicare expenditures, testing performed by independent clinical laboratories is cost-effective. In 1987, the last year for which data is available, Medicare spent approximately $25.89 per Part B enrollee on independent laboratory-provided testing, an amount that is far lower than the average expenditure for such other Part B services as those provided by such physicians or hospital outpatient departments.[7] Even more significant, however, is the economic and human savings that laboratory testing provides through early diagnosis and detection of disease triggering prompt medical intervention, enhancing the likelihood of recovery, and reducing both the human suffering and the amounts that would

[3] ACLA is in the process of attempting to duplicate the consulting firm's analysis for states other than Oregon, and will provide the Committee with the results of this project once it is completed.

[4] *Statistical Abstract of the United States, 1989,* at 469; Bureau of Labor Statistics, U.S. Department of Labor, *CPI Detailed Report,* January 1990, at 156.

[5] Id.

[6] *Bureau of Labor Statistics, 1989,* U.S. Department of Labor, *CPI Detailed Report,* January 1990 at 161.

[7] *See* Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1989 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* at 46. This statistic covers independent laboratories only; it does not include physicians' office or hospital outpatient laboratories. It should also be noted that it has been estimated that in 1989 independent laboratory expenditures accounted for only about three percent of all Part B benefit expenditures. *Ibid.*

have been spent had the disease continued undiscovered. This is the area in which lab testing really proves its cost-effectiveness!

Thus, in the face of escalating cost burdens, laboratories have seen their actual Medicare reimbursement decreased year after year.[8]

C. THE ADMINISTRATION PROPOSAL

With this background, we now review the Administration's FY '91 budget proposal for Medicare reimbursement of clinical laboratories. As noted above, the Administration has offered a broad package of proposals which appear to be designed not to meet the necessary budget targets, but to basically restructure the method by which laboratories are reimbursed. The Administration's proposals are:

- A reduction in the national limitation amounts, which act as a "ceiling" on laboratory payments, for most individual tests to 90 percent of the Medicare fee schedule medians;
- A reduction in the national limitation amounts for profiles and "standardized test packages" to 80 percent of the fee schedule medians;
- A CPI update on fee schedule amounts below the national limitation levels;
- A requirement that laboratories report the price charged to the test-ordering physician when he or she orders a particular test for a non-Medicare patient;
- Implementation of a competitive bidding demonstration for laboratory services.

While the Administration has stated that this package of proposals will save about $60 million in FY 1991, they could actually cause substantially larger reductions, especially in out-years. The Congressional Budget Office (CBO) has reported that just the first three provisions listed above will likely save $85 million in 1991.

Because ACLA understands the need to reduce the mounting Federal deficit, it is prepared to refrain from opposing the Administration's proposal to reduce the national limitation amounts to 90 percent of the fee schedule medians.[9] Association's initial review suggests that this reduction alone could achieve the $60 million reduction in Medicare payments that the Administration seeks.

In addition, ACLA supports the Administration's proposed update of the fee schedules. Although the amount of the update is not specified, ACLA urges the implementation of an update reflecting the full increase in the CPI. Further, ACLA urges that the national limitation amounts also be updated before reduced limitation amounts are calculated. In this way, the reimbursement received by laboratories that are currently subject to the national limitation amount will be adjusted to reflect the effects of inflation.

ACLA believes that the Administration's other proposals will have serious deleterious effects on the quality of and access to laboratory testing services. These proposals appear to stem from a desire not to save money but to restructure the way in which laboratories are reimbursed. If this is true, then ACLA believes there should be a full airing of the issues involved, rather than an attempt to radically revamp the industry through the budget process, which is an inappropriate vehicle for such changes. In addition, as noted above, many of these provisions are not necessary to reach the $60 million that the Administration wishes to save on laboratory expenditures. Further, as noted, the industry is currently preparing for the effect of two new sets of CLIA regulations. This hardly seems the time to implement a major restructuring of the industry that will further reduce reimbursement. Finally, as discussed in greater detail below, there are other more reasonable and more effective solutions if the Administration (and Congress) truly wishes to restructure the test delivery system.

1. Reduction in the National Limitation Amounts for Profiles

The Administration is proposing to establish new national limitation amounts for profiles and "standardized test packages," which would be set at 80 percent of the fee schedule medians. Although it is unclear what is meant by "standardized test packages," as it is not a term commonly used in the laboratory industry, it is believed that the Administration intends this provision to apply to test panels, as well as profiles.

Profiles are groups of tests that are ordered as a package, that are conducted individually and frequently on different instruments and that are often performed on

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[8] Significantly, reimbursement for most other services has *increased* somewhat since 1984.

[9] In recent years, ACLA has endorsed the achievement of laboratory savings through reductions in the national limitation amounts, as this methodology encourages efficiency and is more equitable than other approaches to spending cuts. The most important question, of course, is what the appropriate level for the national limitation amount is.

different specimens. Physicians order profiles because it is more efficient and convenient for them to do so. It is easier for a physician to order a single profile than request numerous individual tests. Moreover, profiles represent good medical practice, as they may lead to the early diagnosis and treatment of medical conditions, a result that ultimately saves Medicare expenditures through early detection of disease. Although profile ordering results in a substantial reduction in the paperwork and time required of the physician and his staff, the laboratory bears the same costs as it would have borne had each test been ordered individually, as each testing procedure must be performed individually.

Unlike profiles, panels are automated tests performed on a single specimen on a single instrument. By doing a single panel, a laboratory may actually perform as many as 24 or 25 different types of analyses. While panels have been assigned procedure codes, most profiles have not been. Both panels and profiles represent appropriate laboratory testing practice that is in the best interests of the patient.

Currently, HCFA has directed carriers to reimburse for panels at a single price just as they would for any test. This is a reasonable approach, as a panel is in reality just like any other individual test. However, for this reason, there is also no reason to reimburse panels using a formula different than is used for other individual tests, which is what the Administration proposes. Moreover, panels have already been subject to a fee schedule rebasing which reduced payment by 8.3% (see OBRA '87).

In the case of profiles, HCFA has instructed carriers to reimburse for each individual test included in a profile, where no procedure codes have been assigned, but to pay no more for the aggregated total of tests than would be charged patients and other third-party payors for the profile. ACLA members bill Medicare for profiles in accordance with HCFA's instructions.[10] ACLA members also provide Medicare the same profile concessions as are supplied to other third-party payors. Thus, if the tests would cost a physician's non-Medicare patient $75.00 when billed separately, but would only cost $50.00 as a profile, Medicare is billed only $50. As a result, Medicare receives the same benefits as other third-party payors. Accordingly, there is simply no reason to enact a separate reimbursement formula applicable to this type of test package.

2. Reporting of the Price To Test-Ordering Physician

The Administration has also proposed that independent laboratories report to Medicare the price charged to the test-ordering physician when he or she orders the same test for a non-Medicare patient. The Administration has indicated it would use this information to reduce the fee schedules in the future, although no specifics re available concerning how this reduction would be effectuated.[11] This proposal is an attempt to revamp the entire structure of laboratory pricing by forcing laboratories to provide Medicare the same price given to physicians for non-Medicare testing. There is simply no reason why physician prices should be used as the basis for a recalculation of the Medicare fee schedule.

Physicians often request pricing concessions from laboratories, and laboratories frequently grant these requested concessions when such physicians order tests for non-Medicare patients and when such physicians decide to pay the laboratory for the service. There are a number of reasons for this practice. As an initial matter, independent laboratories have no testing to perform without test orders from physicians. As a result, physicians have significantly more bargaining power than laboratories. In addition, when a laboratory bills a physician directly, it does so on a monthly basis and provides relatively little information other than the patient's name, date of service, and services performed. The physician acts as the middleman in this transaction, collects from the appropriate third-party payor or patient, and assumes the risk of nonpayment. Medicare, on the other hand, requires a laboratory to provide a great deal more information, which is often difficult, time-consuming and expensive for the laboratory to obtain. In many instances, the laboratory does not have this information, but must obtain it from physicians who are often unresponsive to requests that they supply it. As a result, it is usually more expensive for laboratories to deal with Medicare than with physicians. Congress recognized this

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[10] HCFA is now studying whether carriers are enforcing its policy. It is also studying whether profiles should be assigned procedure codes and whether profile national limitation amounts should be established. Thus, the agency is acting to ensure that Medicare does not overpay for profiles and to correct situations in which overpayment is discovered.

[11] For example, would the fee schedules just be reduced to the lowest physician price or would all the prices be arrayed with the new fee schedule set at some percentile? Would the frequency at which a particular price was charged be taken into consideration?

fact in 1984, when it required that the laboratory fee schedules be calculated from prevailing charges based on prices paid by patients and third-party payors, rather than on amounts paid by physicians.

Moreover, while physicians order tests and increasing volumes result in economies of scale that lower a laboratory's costs, Medicare does not order tests and cannot effect a laboratory's economies of scale. Thus, although Medicare may be a large payor of testing services, it is not a large *purchaser* of testing services, and it is fallacious to argue that Medicare should receive the same price as *true* large volume purchasers, such as physicians.[12]

Finally, compliance with the Administration's reporting proposal would be incredibly burdensome.[13] Each time a laboratory billed Medicare it would have to determine what it would charge a particular physician for the specific test. Laboratories offer thousands of tests to thousands of physicians at changing and often individualized pricing. In 1984, when Congress enacted the current fee schedule methodology, it instructed HCFA to streamline the Medicare billing process a requirement that HCFA has done little to implement. The new proposal would add an additional, highly burdensome requirement, which would only further increase the laboratory's costs of dealing with Medicare.

For these reasons, ACLA strongly opposes this reporting proposal.

3. Competitive Bidding Demonstration

The Administration has also proposed implementation of a competitive bidding demonstration project for laboratory services. Like the other proposals discussed above, this proposal represents an attempt to radically restructure Medicare's laboratory reimbursement system. Although there is no description of the plan in the budget proposal, ACLA expects it would be based on an earlier proposal developed by a health care consultant working under contract with HCFA. When HCFA tried to implement this plan in the past, serious weaknesses in the proposed model prompted Congress to repeatedly block implementation.[14]. ACLA urges Congress to reject this proposal for all the reasons set out below.

Competitive bidding for laboratory services is not a new idea. In late September, 1985, HCFA entered into a contract with Abt Associates of Cambridge, Massachusetts to design, implement and evaluate a competitive bidding demonstration for procuring laboratory testing services reimbursed by Medicare. No final description of the project was ever issued to the public nor was the industry ever given an opportunity to comment on the final plan. However, through conversations and informal meeting, details about the proposal did emerge.

Under the Abt model, independent laboratories that wished to bid would have to agree to provide 60 specified tests, either in-house or by arrangement with other labs. Winning independent laboratories would be paid at winning prices; losing independent laboratories would be paid at prices *below* the winning bid. In fact, the higher their bid was above the winning bid, the lower their reimbursement would be.

Only independent laboratories were required to bid to participate. Physician office laboratories would be precluded from bidding but would still be paid at bid winning prices. Hospital laboratories might or might not have to bid, depending on whether they provided services to non-patients, in addition to hospital outpatients. Although the Administration proposal does not specifically mention the Abt model, it seems reasonable to assume that this plan was the inspiration for the inclusion of the Administration's competitive bidding provision. Moreover, many of the differences discussed below are endemic in any competitive bidding plan—not just the Abt proposal.

ACLA has a number of specific objections to competitive bidding for laboratory services. However, its major objection can be summed up simply: *Competitive bidding simply will not ensure quality laboratory services at low prices and could harm beneficiaries.* The system virtually ensures that quality will deteriorate and the complex reimbursement system may actually increase costs. In addition, as few details have been provided, it is virtually impossible to know how the system would

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[12] ACLA has prepared a position paper reflecting proposals that Medicare payment should be tied to prices charged to physicians which it will supply to the Committee if it wishes it. The document is not attached to this statement because of the 10 page limit applicable to this testimony.

[13] ACLA notes that the Federal Government already has substantial information about laboratory charges to physicians. Thus, the proposed requirement, in addition to being unduly burdensome, is unnecessary.

[14] A similar moratorium was originally included in the Senate Finance Committee reported version of OBRA '89; however, it was "stripped" before Senate passage.

operate in practice. It is not enough to simply rely on the Abt model because no one, neither the industry nor Congress, has ever had the opportunity to review it, provide guidance or debate its features. The most basic questions about the operation of the plan have yet to be answered.

In addition and of utmost significance, competitive bidding for laboratory services is likely to lead to serious deterioration in quality. In other instances where competitive bidding was attempted, some laboratories submitted unreasonably low bids to win the contract but then could not cover the costs of providing the services and were forced to cut corners—with disastrous results. For example, when the Air Force awarded a contract to a laboratory for screening Pap smears of female dependents of servicemen on the basis of competitive bidding, the winning laboratory performed so negligently that women's lives were placed at risk. The Air Force was forced to impound over 700,000 Pap smears which they found contained numerous errors. Other attempts to use competitive bidding for laboratory services have met with similar fates.[15]

The treatment accorded "losing" laboratories under the Abt Model is also disturbing. These labs would be reimbursed at levels substantially below what they bid and below the "winning" bid. If the losing entities initially bid prices that they believed were realistic from a cost and competitive standpoint, then it follows that they would be reimbursed at a level that might not even allow them to cover their costs. As a result, they would find it difficult to provide quality services.

These problems are exacerbated by the fact that the Abt model does not guarantee any volume of testing to the winners. Most competitive bidding plans offer a *quid pro quo*—guaranteed volume in exchange for reduced prices. Abt proposed that laboratories provide reduced pricing without any guaranteed volume. Thus, under this plan, a laboratory would have no way of estimating what its volume would be when it was formulating its bid. This fact would make it extremely difficult for laboratories to develop intelligent, rational bids that reflected the cost of providing a particular volume of service. Because there is no way to assure that the bid price would relate to the actual cost of providing the service, the quality problems noted above would be virtually assured. To risk such a deterioration in quality when Congress has just recently passed CLIA'88, which is designed to ensure high quality, seems dangerous and counterproductive.

Further, the Abt model treats the three categories of laboratory competitors—physician office, hospital and independent—differently, thereby undercutting many recent legislative reforms that were designed to ensure a level playing field among various classes of labs. As envisioned by the Abt model, physician office laboratories would automatically be paid at the bid winning price. Those hospital laboratories that provide testing to hospital non-patients would be treated in the same fashion as independent laboratories, *i.e.*, they would have to bid to provide services and would be reimbursed in accordance with the formula discussed above. For hospitals that perform testing only on hospital out-patients, however, bidding would not be required, but these hospitals would be paid at bid winning prices.

Numerous problems are created by this aspect of the proposed design. Independent, hospital and physician office laboratories compete for testing business. In fact, physician office and hospital laboratories have a natural advantage in this competitive battle, as they have captive patients that they control. Independent laboratories have no such benefit because they have no patients of their own and are dependent on a physician request to trigger the testing process. Despite this competitive disadvantage, it is the independent clinical labs that would bear the greatest risk of being reimbursed at a level below the winning bid if they were classified as "losers." Physician office labs would never bear that risk and hospitals would only bear it if they provided services to non-patients. Obviously, this plan effectively destroys the "level playing field" created by recent legislation, the purpose of which was to ensure that all laboratories—physician office, hospital, and independent—are to be treated the same by the Medicare payment rules.

Further, although the purpose of competitive bidding may be to provide Medicare with the benefits of the free market system, in fact it appears likely that the plan could have anticompetitive effects. Testing for Medicare beneficiaries represents a large percentage of many laboratories' business. If a lab were unable to bid on Medicare work, or found that it was losing money on Medicare work because it was a "losing" bidder, it might be forced to close down or merge with another large lab

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[15] *See* J.R. Schenken, M.D., "Caution on the Slippery Road to Competitive Bidding," *Medical Laboratory Observer* at 57 (March, 1983).

that was in a stronger financial position. Either way, the effects would be increased concentration in the laboratory industry, reduced competition and curtailed access.

Moreover, even if the Abt plan were only implemented as a demonstration, it would be both expensive and burdensome. Today, each carrier reimburses laboratories on the basis of a single fee schedule. Under the competitive bidding plan, specific pricing information would have to be retained for each of the participating laboratories. For laboratories providing services to physicians located outside the demonstration area, the affected carrier would have to retain fee schedule information. For laboratories providing testing to physicians located inside the demonstration area, the carrier would have to keep track of the winning prices and the various losing prices. There is no question that administration of this plan would be costly, replete with errors, and burdensome.

For all of these reasons, ACLA opposes the Administration's competitive bidding proposal.

4. Summary

With the exception of the reduction in the national limitation amounts to 90 percent and the CPI update, ACLA opposes the Administration's proposals for clinical laboratory testing services. As discussed above, these provisions appear to represent an attempt to effect major restructuring of the clinical laboratory testing market under the guise of the budget process. Further, such revamping would wreak havoc in the industry, harm quality care and reduce access. If Congress is interested in changing the delivery of testing services, ACLA urges it to consider the proposal set out below.

D. CONGRESS SHOULD ADOPT DIRECT BILLING LEGISLATION

If the Administration (and Congress) wish to reform the structure of clinical laboratory testing, then they should reject the proposals discussed above, and instead, enact direct billing legislation, which would prohibit physicians from billing for tests that they do not perform. Direct billing would correct the problems that were the impetus for most of the Administration's proposals, without their unfortunate side-effects on quality and access.

Under the current system, in most states a physician ordering a test for a non-Medicare patient can either request that the laboratory bill him or that it bill the patient or third-party payor directly. If the laboratory bills the physician, then he pays the laboratory, and bills the third-party payor or patient, usually in an amount that exceeds the price that the laboratory charged him. The physician thus earns a profit on this testing, even though he plays no role in the testing process other than periodically taking the specimen and sending it to the laboratory. This mark-up may compromise physician decisionmaking, lead to over-utilization and result in the selection of a laboratory for reasons other than the quality of its service.

As the government has lowered Medicare reimbursement to laboratories since 1984, it has placed physicians in a pivotal position vis-a-vis their relationship with laboratories. Because laboratories cannot perform testing without a physician's order, physicians can force laboratories to grant substantial discounts if the laboratory wishes to obtain a physician's patronage. As noted above, to some extent, these lower prices may be justified by the lower costs of dealing with physicians; however, in some cases, the increasing competition for physician business may result in physicians receiving prices that are artificially low. Physicians can then mark up these prices by sub amounts when billing patients and third party payors.[16] Thus, patients and third-parties pay substantially more for testing than physicians or Medicare, which reimburses at levels that are significantly lower than the prices that it is billed.

Thus, there is in effect the following "Alice-in-Wonderland" situation. Physicians act as brokers of laboratory services, paying the lowest amount because they control the volume of testing. Although physicians have no involvement in the testing process, they are permitted to mark-up these tests by huge amounts, the costs of which are borne by third-party payors and patients. Medicare pays the next lowest amount, as the government has protected itself through implementation of the fee schedules and the national limitation amounts. Finally, patients and third-party payors pay the most. Reducing Medicare prices to the same amount that physicians pay, as the Administration may be implicitly proposing, will only make this situa-

[16] Further, because physicians earn substantial profits on each test that they order, they also have an incentive to overutilize testing services.

tion worse.[17] The solution is not to have Medicare pay the same price as physicians; it is to remove the physician completely from this calculus.

Accordingly, the Federal Government should do for the private sector what it did in 1984 for Medicare, namely, require laboratory "direct billing" to patients and third parties by prohibiting labs from billing physicians. Such an enactment would eliminate physician markups, incentives to overutilize testing services, and practices that impair quality. Laboratories could adopt a more rational pricing system that would benefit third-party payors, patients and Medicare, as laboratories would no longer be forced to adjust for unjustified physician discounts.

Direct billing would also mean that price competition among laboratories could take place at the patient and third party level instead of at the physician level where benefits do not accrue to patients and third parties. New York State has long had such a direct billing system and, as a result, patient prices are significantly lower in New York than the national average. One ACLA member notes its revenues per test in New York for non-Medicare patients and third parties is 20 percent lower than the average of its other labs.

Moreover, because the Medicare fee schedules were originally set based on prices to patients and third-party payors, Medicare prices in direct billing states are usually lower than in other states, a fact that demonstrates the financial benefits of direct billing. Thus, the average Medicare prices of a number of ACLA members for nine tests in the following states are as follows:

	Average Medicare price
California	14.66
Texas	13.63
Illinois	13.46
Michigan	12.28
New York	11.95

New York and Michigan, both of which have average prices that are substantially below those prices in California, which ranked highest, are direct billing states: the average price in New York is about 18 percent below the average price in California; Michigan is about 16 percent below.

Direct billing would reform the laboratory industry in a beneficial way without injuring quality or access. It would reduce the disparity between what private patients pay and what Medicare reimburses for laboratory tests, and it would permit Medicare to gradually reduce the amount it reimburses without endangering quality and access for Medicare patients.

CONCLUSION

ACLA urges that, if necessary, Congress reduce the national limitation amounts for all tests to 90 percent of the fee schedule median and approve a full CPI update for amounts below the fee schedule and for the national limitation amounts themselves. The remaining proposals should be rejected. Finally, Congress should consider the adoption of direct billing legislation.

STATEMENT OF THE AMERICAN COLLEGE OF NUCLEAR PHYSICIAN AND SOCIETY OF NUCLEAR MEDICINE

The American College of Nuclear Physicians and the Society of Nuclear Medicine represent the practitioners of nuclear medicine, in total more than 12,000 nuclear medicine physicians, scientists and nuclear medicine technologists.

Nuclear medicine, one of the newest medical specialties, remains on the forefront of new diagnostic and therapeutic procedures. Each year in this country over 100 million nuclear medicine examinations are performed, either on the patient himself, or on specimens of body fluids and tissues. Any patient entering a hospital is very likely to have at least one nuclear medicine procedure during his stay.

An understanding of the differences between nuclear medicine and radiology is critical to developing proper values for reimbursement of nuclear medicine under a resource-based relative value scale.

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[17] These physician-generated price pressures also threaten quality.

Nuclear medicine suffers from an identity crisis outside our own field. We are often confused with our colleagues in diagnostic radiology. This confusion arises because, for some of our procedures, the output is on film that is similar to x-ray film. That however, is where the similarity ends. Nuclear medicine is not radiology.

Perhaps the differences between radiology and nuclear medicine can be demonstrated by looking at several representative procedures.

The first of these is bone imaging and bone x-ray. In a bone x-ray, a beam of x-rays is passed through the bone in question and a "snapshot" of what that bone looks like at that instant is made. The entire life history of the bone is represented on the ANATOMIC image of the bone.

A bone scan image however, is as far from an x-ray as one can get. In this case the patient is given a radioactive drug (radiopharmaceutical) intravenously, which has been designed by a radiochemist to localize in bones. The factors that affect the radiopharmaceutical localization relate to the metabolic activity in the bone, rather than its anatomy. A bone image is a "snapshot" of the METABOLIC activity of the bone at the time of the image.

Because we study metabolism, rather than anatomy, studies have shown that metastatic cancer in bone may be visualized six to 18 months earlier on the bone image than the x-ray. Before nuclear medicine became available, whole body x-rays were taken of the skeleton when metastatic bone cancer was suspected. Thirty to fifty percent destruction of the bone architecture is required before the metastases could be detected by x-ray. Bone imaging with radionuclides has now completely replaced the x-ray as the initial screen, as this image of metabolic activity will detect an abnormal focal increase in the area of the metastasis long before it can be seen on an x-ray.

As with all other nuclear medicine procedures, the nuclear medicine physician first approves the request. The procedure is accomplished by the nuclear medicine technologist under his direction. Upon completion of the procedure the nuclear medicine physician evaluates the final images before the patient is discharged. Since the nuclear medicine patient is administered a radiopharmaceutical and any repeat views at a later time, would require additional doses of radiotracer, proper instrument and pharmaceutical quality control to obtain a high-quality image for each test is an essential part of our practice. Although bone cancer has been the major use of the bone image, we have begun to study a variety of other bone lesions such as osteomyelitis, stress fractures, Paget's disease, and other benign lesions affecting the joints. Most are evaluated using serial sequences to assess regional blood flow along with the bony localization. By applying SPECT (single photon emission computed tomography) imaging to the planar bone imaging we are often able to detect lesions that were not clearly seen on the planar bone image and missed on the x-ray. The nuclear physician must determine which part of the body is to be examined with SPECT, as this is not always obvious.

Stress radiothallium myocardial perfusion probably constitutes 25–30 percent of the nuclear medicine laboratory activities. These thallium studies are used for multiple cardiac problems particularly in determining regional myocardial damage and whether the lesion is permanent (scar) or potentially reversible (ischemia).

The nuclear medicine physician's involvement begins with the request, where he or she reviews the patient's medical record and consults with the referring doctor to acknowledge the appropriateness of the study and requirements for its performance. The nuclear medicine physician then supervises or arranges for cardiology to stress the patient and authorizes the radiothallium to be administered to the patient at the appropriate time, usually by the nuclear medicine technologist. Tomographic images from the data obtained by the nuclear medicine technologist are then reconstructed for interpretation by the nuclear medicine physician. The nuclear physician must at this point determine if delayed images are necessary to complete the patients' study.

The importance and cost-effectiveness of this technique is demonstrated by the patient with chest pain and signs of a heart attack that requires hospitalization, usually in a coronary care unit at $800–$1,200 dollars a day. The duration of the CCU stay and the need for coronary artery catheterization can be influenced by the radiothallium study (modified stress protocol). The radiothallium myocardial perfusion study, whether done with tomography or planar imaging is a valuable tool to determine the short and long term care of the cardiac patient.

While the bones and hearts of many patients look similar on x-ray, no two patients' organs function identically. Therefore, much more intensive physician to physician, and physician to patient interaction is required to sort out the correct medical diagnosis than is required in most branches of diagnostic radiology.

The dichotomy of practice is further reflected by who is practicing nuclear medicine. A recent survey conducted for the College and Society reveals that 83 percent of those physicians who devote more than 50 percent of their professional activity to the practice of nuclear medicine were certified by The American Board of Nuclear Medicine rather than The American Board of Radiology. In contrast, 65 percent of those physicians whose practice of nuclear medicine was less than 20 percent of their professional activity were certified by The American Board of Radiology.

There are other striking differences between radiology and nuclear medicine practice. Since we deal with radioactive materials we are more closely regulated than any other medical specialty. Our practitioners must either be onsite, or in the immediate vicinity of the site, at any time a study is being performed. Our regulators at the Nuclear Regulatory Commission have concluded that more physician interaction with the patients, technologists, physicists, chemists and referring physicians is required for the safe and proper application of radiopharmaceuticals.

Current x-ray machines contain a device known as a phototimer. This device regulates the x-ray exposure to produce an optimal quality film in almost all patients. No such device exists in nuclear medicine. Patient studies, and study parameters, often change patient to patient and are dependent upon the tentative diagnosis, the type of device (standard or tomographic), and the radiopharmaceutical employed. The data processing parameters are also quite different patient to patient, often requiring the combined talents of the physician, technologist and physicist to get to the correct diagnosis.

From this description we hope it is obvious why the attempt of the American College of Radiology to create an RVS for nuclear medicine went astray. The ACR RVS, as spelled out in detail in the PhysPRC report, was primarily based on a survey of charges made for procedures. It is not, like the Harvard RVS, a resource-based study. The ACR surveyed approximately 3,000 radiology practices. None of these practices were solely nuclear medicine practices. The full-time nuclear medicine practitioner was not, therefore, represented in ACR's sample. In fact, for more than half of the nuclear medicine CPT codes, the ACR survey received 25 or fewer responses. This indicates that the respondents as a whole practiced very little nuclear medicine. It clearly calls into question whether there were sufficient responses to yield valid charge data.

The ACNP and SNM subsequently contracted for two separate studies—one by Abt Associates and the second by Health Technology Associates—to survey practicing nuclear medicine physicians and to compare the ACR survey results with the charge data from the HCFA BMAD files. The results were comparable. Both demonstrate that the ACR methodology had systematically undervalued Nuclear Medicine procedures, in relationship to the commonly-performed radiology procedures. Copies of both of these studies have been provided to PhysPRC staff. We would be glad to provide them to Congress.[1]

Congress last year recognized that the Radiology RVS had gone astray, and approved a partial two-year exemption for the practitioner who does 80 percent or more nuclear medicine procedure. This was designed to provide time for a considered decision of the best way to develop a fee schedule for nuclear medicine for 1992 and subsequently, as well as to provide interim relief for the nuclear physician.

Nuclear medicine appreciates the action taken by Congress to provide this partial, interim exemption from the radiology fee schedule. As an interim measure, this has protected most full-time nuclear physicians from the errors of the radiology fee schedule, which had led to reductions in fees averaging 30 percent or more in many localities. But some problems remain. Historically, many nuclear physicians have practiced as part of radiology groups. Their billings have been through the group, not by individual physician number. At least in 1990, these physicians have been trapped in the radiology fee schedule, even if they practice 80 percent or more nuclear medicine. It is true that nuclear physicians practicing in a radiology group did not suffer as great a reduction in income from the radiology fee schedule as those

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[1] To check the validity of the Nuclear Medicine charges collected in the ACR charge survey, the College and Society contracted with Abt Associates, Inc. (the same firm that conducted the charge survey for ACR), to conduct a charge survey for practicing nuclear physicians. Abt surveyed 20 representative Nuclear Medicine codes and 4 radiology codes. A charge-based RVS was constructed for these services, using the single view chest x-ray (CPT-4 code 71010) as the base procedure to maintain comparability with the RYS created by ACR and accepted by HCFA. In all services surveyed in our study, the Nuclear Medicine charge data produces higher relative value values than the charge-based RVS developed by ACR and accepted by HCFA. The computer analysis of charge data from BMAD files conducted by Health Technology Associates provided similar results.

practicing alone. But the application of the radiology fee schedule to them is equally flawed.

We have received reports of other problems in implementation. For example, a physician from South Dakota, who practices about 65 percent nuclear medicine and 35 percent internal medicine, saw his nuclear medicine allowed charges reduced about 30 percent when the radiology fee schedule came into effect in 1989. For the purposes of this rule, he was a radiologist. But as his nuclear medicine billings are less than 80 percent, he has not qualified for the 1990 nuclear medicine exemption. He remains under the radiology fee schedule, his allowed charges rolled back 30 percent. He is the only nuclear physician in his part of South Dakota.

The Harvard School of Public Health now has underway a survey of nuclear medicine. Members of our organizations serve on a technical advisory panel and have had constructive discussions with Professor Hsiao and his colleagues. We believe initial problems with some of the vignettes have been worked out.

We are uncertain, at present, whether or not the Harvard Study will be able to develop satisfactory cross linkages between nuclear medicine and other specialties. We won't know this until the study is further along. However, our belief is that a resource-based RVS, if properly developed, is likely to provide a more equitable and more objective basis for a fee schedule for nuclear medicine than the existing radiology fee schedule.

The Physician Payment Review Commission has noted that "the radiology fee schedule values may need substantial revision to make them consistent with a resource basis" and has, in fact, concluded that "the relative values from the Radiology Fee Schedule should be revised before using them in the Medicare fee schedule." From the perspective of nuclear medicine, we agree. The radiology fee schedule, from a lack of appropriate data, has systematically undervalued nuclear medicine.

The Physician Payment Review Commission has proposed to refine the radiology fee schedule drawing on "several sources of information: the relative values from the RFS, relative work values from the Hsiao study, the Commission's estimates of practice expense components for these services, and the data from several surveys of the American College of Radiology."

We have outlined above the differences between the practice of radiology and that of nuclear medicine. The surveys of the American College of Radiology may provide useful information about radiology, but they do not provide accurate information about nuclear medicine. They should be disregarded in developing a fee schedule for nuclear medicine.

For nuclear medicine, therefore, we cannot recommend the approach of attempting to revise the radiology fee schedule. That schedule, for nuclear medicine, has gone too far astray. There are too many methodological errors. The only course is to start anew.

Specifically, we recommend:

—Congress should recognize the important distinctions between nuclear medicine and radiology by separating nuclear medicine from radiology for the purposes of implementing the fee schedule for 1992.

—Nuclear medicine should also be exempted from the radiology fee schedule for the transition year of 1991 and be reimbursed on the same principles as other physicians for that time.

—The definition of a nuclear medicine physician should be revised to recognize what we have learned in implementation. This could be done either by recognizing board certification or by revising the percentage used for definition of a nuclear physician.

Farther into the future, we do see several complexities in working out a resource-based fee schedule for nuclear medicine. These must be addressed, either by Professor Hsiao's group or by PhysPRC after completion of the Harvard study. Many of these issues have been raised by PhysPRC in its report to Congress. Accounting for both the time value and the practice costs for complex diagnostic studies is more difficult than for most medical practices. These resource issues must be addressed.

First, the Harvard system of estimating the time and the complexity of the physician component focuses on direct patient contact. It does not account for the time spent in supervision of non-physicians, particularly when this supervision includes several procedures going on at once, or several patients being prepared simultaneously. The surveys are likely to estimate only the time in direct contact with the single patient and in reading the image. We need to review the results to be sure that other physician time essential to the diagnostic procedure, including compliance with radiation safety regulations of the Nuclear Regulatory Commission, is not overlooked.

Second, we believe the estimation of the practice cost component will be more complex than for other physician services.

Nuclear medicine physicians practice both in hospitals and in clinics. Practice costs differ in the two settings. In the hospital, most practice costs are usually covered by the hospital. But at some institutions, the Ph.D. physicists or other scientists who are essential to our practice are covered out of practice income.

At the clinic, of course, all of the costs are covered out of practice income. But the physicists time will not be included in the survey, at least in the survey being done by Harvard, of the physician component. These expenses are different from the usual overhead practice costs incurred in the typical physician's office.

We are confident those complexities can be worked out; however, we do want to bring them to your attention and ask that they not be overlooked.

In closing, let us express our admiration for the outstanding work of The Payment Review Commission and its staff. Congress and the PhysPRC have led the way toward a system of intelligent and equitable reimbursement. We look forward to continuing to work with Congress and the Physician Payment Review Commission.

STATEMENT OF THE AFL–CIO

We are pleased to present the views of the AFL–CIO on the tax proposals included in the Administration's budget for fiscal year 1991.

Although there are over 30 proposals for tax change, we will confine our comments to those which concern us the most.

But before beginning, we must note that the Joint Tax Committee says that the President's "revenue" proposals cost over $33.6 billion over the first 5 years. Thus, the President's revenue package raises the concept of smoke and mirrors to a new high.

THE ADMINISTRATION'S "SAVINGS" INCENTIVES

Capital Gains: We are opposed to the proposed cut in the capital gains tax rate. We believe that it is unfair to tax the wages and salaries of working people at a higher rate than the profits made by the wealthy on their sales of stocks, bonds, real estate and other property.

The Administration's proposal would allow a 30 percent capital gains exclusion for profits on assets held for 3 or more years; a 20 percent exclusion for assets held 2–3 years and a 10 percent exclusion for any profits made on assets held between 1 and 2 years. These exclusions would drive the effective tax rates on capital gains for the nation's highest income taxpayers down as low as 19.6 percent.

This proposed reinstitution of a preferential tax rate on the income of the wealthy amounts to a repudiation of the 1986 effort at tax reform. That legislation's major accomplishment was to stop the tax distinction between the capital gains of the wealthy and the ordinary income of everyone else. By doing so, the "86" Act ended one of the most costly and unfair features of the tax structure and did much to eliminate the tax shelter industry which was so heavily based on schemes to convert ordinary income into preferentially taxed capital gains.

Indeed, the consensus to cut the progressive tax rate structure so sharply in 1986 was based on the elimination of the capital gains preference. The rich gave up some of their opportunities for tax shelter and tax avoidance in exchange for a drastic reduction in the progressivity of the income tax—the top marginal tax rate on the wealthiest taxpayers was reduced 44 percent from So percent to 28 percent.

The justifications for the proposal as put forward by the Administration are far from convincing.

For example, the revenue consequences of the Administration's proposal—an *increase* of $4.9 billion in the first full year and a 1990–1995 total increase of $12.5 billion—have been sharply disputed by the staff of the Joint Tax Committee. In fact, the JCT estimates a 6 year loss of $11.3 billion.

The Administration's contention that a capital gains rate differential promotes savings and new longer term investments is a matter of opinion and not of fact. Economists do not know how much of any new tax benefit would be saved or invested and how much would be spent on consumption—in the U.S. or overseas.

There is agreement however, that any increases in private savings that might come about would be offset to the extent the tax cuts are "financed" by increases in the Federal deficit, or by foregoing federally supported public investment type expenditures. Moreover, a return to the days of tax shelters would distort investment patterns as tax avoidance considerations, rather than economic merit, become dominant factors in investment decisions.

Another aspect of the capital gains preference that is indisputable is its lack of fairness. Joint Tax Committee analyses of the distributional effects of the Administration's proposal show that 83 percent of the benefits will flow to those with incomes of over $100,000; and, that group's average reduction would be nearly $4,500. IRS data also show that for most all working people a capital gain is a once or twice in a lifetime event arising out of the sale of a home, farm or family business. In contrast among the wealthy, capital gains represent a substantial and continuing part of their income.

We hope you will reject the Administration's capital gains tax relief proposal, and we also urge that you resist the temptation to recommend one of your own.

Family Savings Account: This proposal in our view promises far more than it can deliver in terms of its impact on savings rates and its benefits to most taxpayers. The proposal would allow non-deductible contributions (maximum of $2,500 per year) to an account that, if maintained for seven years, would allow tax free withdrawals of any interest earned on the account. During the seven year period, the interest build up would also not be taxed.

Obviously, the only beneficiaries of the proposal would be those who could afford to tie up their money for the period involved. Since IRA's, 401-K's and the like would still be allowed—and these programs tend to be more generous—we suspect that most taxpayers have all they can do to take advantage of existing law tax favored savings programs. As a result, wealthier families who have exhausted all other tax deferral opportunities, would receive a disproportionate share of the benefit.

The proposal would more than likely cause some rearranging of private savings but it is not likely to result in a net increase. Also, in view of the longer term budget deficit problem, we believe it to be rather disingenuous to offer a measure which costs very little initially but builds rapidly into a significant revenue loser.

The Administration's third "savings" incentive is the proposal to permit individuals to withdraw without penalty up to $10,000 from their IRA's for a "first-time" home purchase provided the home price is no more than 110 percent of the median home price in the area and the individual did not own a home for the prior three years.

We have no objection to this proposal. In fact it seems unduly complex and restrictive. If Congress is inclined to enact this measure, we would suggest that the eligibility qualifications be relaxed and similar penalty free withdrawals be permitted for spending on higher education.

We must add, however, that the Family Savings Account proposal with its promise of some small benefits seven years away to a limited group of moderate income taxpayers and the IRA home purchase measure do not in any way counterbalance the huge benefits the capital gains proposal holds out to the wealthy. Thus, to the extent that these three proposals are considered to be a package deal, as proposed in the Administration's bill S. 2071, introduced by Senator Packwood on 2/6/90, we would oppose such a package.

CHILD AND DEPENDENT CARE TAX CREDITS

The Administration proposes a new refundable tax credit for low income families of up to $1,000 for each dependent child under age four. The credit would phase out initially at $13,000 of income. In addition, the present law non-refundable child and dependent care credit of up to 30 percent of employment related child or dependent care would be made refundable. Eligible families could claim either the new child care credit or the child and dependent credit whichever is more to their benefit.

We have no objection to these measures, but we would prefer to see the House passed proposal of last year (H.R. 3299). That measure is more generous and would reach more families. It must, at the same time, be recognized that none of these measures are a substitute for a comprehensive program of help for children and working families.

PENSIONS

The AFL-CIO strongly opposes the President's proposal to allow so-called "surplus" pension assets to be used for retiree health benefits unless it is linked to necessary changes in ERISA covering pension plan termination and reversion issues and unless it provides for certain protections for the retiree health benefits. In our view, pension fund assets are held in trust for the exclusive benefit of participants and beneficiaries.

However, given the experience with the termination of defined benefit plans (over the last decade, over $20 billion of the so-called "surplus assets" have been re-

claimed by employers), we strongly urge this Committee to enact legislation to also address the important issue of pension stripping.

In the context of a bill to provide benefit protections in cases of reversions, we would work with Congress in developing a proposal to allow the so-called surplus assets to be used to fund retiree health benefits, but, again, only if adequate protections are put in place for both the pension and retiree health benefits.

We believe that, short of a total ban on terminations and reversions, active workers and retirees who experience a termination and reversion should be entitled to a fair share of so-called "excess assets." These "excess assets" should not be available to employers until an adequate cushion exists for any ongoing plans that would shield worker and retiree pension benefits from unexpected market downturns and inflation. Financial incentives, in terms of the amount of excess assets available to employers, should exist to encourage the continuation of defined benefit plans. Some measures are also necessary to adequately protect pension benefits that are provided in the form of insurance annuities by companies with unstable financial standing.

The President's proposal to transfer so-called surplus pension assets to pay for retiree health benefits falls short of these goals. In addition, the proposal fails to provide adequate protections for the security of these retiree health benefits. Unlike private sector pensions which are subject to minimum standards under ERISA, retiree health benefits are not comparably safeguarded under Federal laws.

Without basic retiree benefit protections, proposals to transfer excess pension assets to fund retiree health benefits are nothing more than back door reversions for employers. Most employers with defined benefit plans will have a significant financial incentive to transfer excess assets to fund retiree health benefits. According to the Department of Labor, 50 percent of defined benefit plans are funded over 150 percent of current liability. For purposes of FASB, this movement of assets will decrease employers' paper liabilities. More importantly, the transfer approach eases employers' cash flow for funding health benefits, because employers do not have to generate new income for payment of retiree health benefits. This "windfall" to employers is shared by the Treasury in the form of a short-term revenue gain.

The potential losers in this reversions shell-game are workers and beneficiaries. It is for this reason that the following retiree protections should be included in the legislation:

- Assets transferred from an over-funded pension account for the purpose of meeting retiree health care obligations can be used only to finance benefits for the participants in the pension plan.
- Plan sponsors should be allowed a one time transfer of excess pension fund assets that exceed 150 percent of termination liability.
- Excess assets diverted from pension funds for retiree health care could only be put into 401 (h) and, or some other government sponsored vehicle.
- Employees should be vested in their retiree benefits to insure that benefits may not be arbitrarily reduced or eliminated.
- Employers choosing to divert pension fund assets into retiree health accounts must maintain current levels of benefits and out-of-pocket expenses.

The same basic issues of benefit security exists for both pension transfers and terminations. It is simply bad public policy to move a proposal to raise taxes at the expense of the retirement income of this country's elderly.

ENTERPRISE ZONES

The Administration's tax proposals for Enterprise Zones will not create additional jobs nor help to revitalize depressed areas. Rather, they will encourage the reshuffling of existing jobs from place to place, and heighten destructive inter- and intrastate competition for industry.

The recent history of enterprise zones set up under various state programs includes numerous instances where existing firms have relocated into zone areas, contributing nothing to net job creation, but nevertheless involving the expenditure of public funds. It is difficult to determine whether businesses have set up, expanded, or relocated in enterprise zones due to the availability of tax subsidies or due to other factors, such as nearness to markets and adequate public facilities.

The 5 percent refundable tax credit for "qualified" employees would result in an inequitable tax situation among workers depending upon where they work. The "qualified" employees would get a 5 percent refundable tax credit if they worked in the enterprise zone and had total wages less than $20,000, but, the credit would only apply to the first $10,500 wages worked in the enterprise zone. And though an improvement over the existing targeted jobs tax credit which goes to the employer not

the employee, we suspect that employers would use the credit as an excuse to pay lower wages. Also, in many distressed areas, existing and potential employment would be outside the zone, and workers with the same income would not receive the credit. Thus, residents of the zone would not receive the credit if they worked elsewhere, while nonresidents might.

Eliminating capital gains taxes for property located in a zone would benefit owners of older businesses, not new industry and then only when they sell out. The expensing of contributions to capital proposal also is a measure that would be most helpful to highly profitable businesses which need rapid write-offs to wash out against other income rather then newly started businesses. We are, therefore, opposed to the Administration's Enterprise Zone proposal.

MEDICARE HOSPITAL INSURANCE (HI) FOR STATE AND LOCAL EMPLOYEES

The AFL–CIO opposes this provision because it breaks Congress' agreement with the states made in 1985 that only new state and local employees would be put in the Medicare system. The President's proposal eliminates the "grandfather" for existing employees and would increase the cost to state and local governments which in most instances have programs already in place.

AIRPORT AND AIRWAY TRUST FUND EXCISE TAX

AFL–CIO opposes the President's proposal to repeal the aviation tax reduction trigger and increase the air passenger ticket tax. This Administration and the prior Administration has failed to expend the funds in the airport trust funds in a timely manner. Therefore, the AFL–CIO opposes both the elimination of the trigger and an increase in the tax until these funds are expended for the purpose for which they are collected.

LOW INCOME HOUSING CREDIT

We support the extension of the Low Income Housing Tax Credit through 1991. The tax credit has helped foster the construction of 100,000 rental housing units for lower income people since 1986. While we support the tax credit, this is no substitute for legislation pending this year in the Senate and House Banking Committees for comprehensive housing legislation. This includes authority for a badly needed assisted housing production program, aid for first-time buyers, non-profit assistance, support for publicly assisted families in privately-owned units which are in danger of losing their subsidies, and such traditional programs as low rent public housing and aid for the elderly and handicapped.

PERMANENT EXTENSION OF EMPLOYER PROVIDED EDUCATIONAL ASSISTANCE AND GROUP LEGAL SERVICES

The AFL–CIO strongly supports the permanent extension of employer-provided Educational Assistance and Group Legal Services. Both of these important tax provisions expire on September 30, 1990.

Employer provided educational assistance (Sec. 127) allows a worker to exclude $5,250 of employer-provided educational assistance. Many workers use this assistance to improve their skills. The AFL–CIO also strongly supports making graduate education eligible under Sec. 127. We commend Senator Pat Moynihan for his leadership in this effort.

Group Legal Selvices (Sec. 120)—should also be extended permanently. However, the Committee should consider increasing the $70 annual premium in order to account for annual increases in providing this necessary employee benefit. The AFL–CIO wants to thank Senator Bob Packwood for his leadership in maintaining this important employee benefit.

All tolled the revenue proposals of the Administration's budget add up to a further shifting of the nation's tax burdens onto the shoulders of moderate and middle income working Americans. The wealthy would be bribed to save and invest through renewed opportunities for massive tax avoidance, while most all other Americans would be asked to foot the bill. We believe the income tax must be made fairer and more productive—the Administration's proposals forward neither objective.

The AFL–CIO knows that this Committee has the responsibility of generating over $14 billion in new tax revenue to meet its budget obligation. To accomplish this in the fairest way possible, the Committee should look first toward progressive changes in the rate structure.

STATEMENT OF THE AMERICAN ORTHOTIC AND PROSTHETIC ASSOCIATION

I. INTRODUCTION

The American Orthotic and Prosthetic Association (AOPA) is the association representing the approximately 2,300 certified practitioners of orthotic and prosthetic medicine in the United States. AOPA members design and fit braces and prostheses that enable physically challenged individuals to overcome often serious and crippling injuries and return to productive lives. AOPA appreciates this opportunity to comment on the Administration's fiscal year 1991 budget proposals for Medicare Part B reimbursement.

II. BACKGROUND ON THE ORTHOTIC AND PROSTHETIC INDUSTRY AND MEDICARE REIMBURSEMENT

Orthotic and prosthetic (O&P) services involve the activity of a highly-trained, certified medical practitioner who evaluates the needs of each individual patient, often in emergency situations, and consults closely with the prescribing physician to ensure that the patient is fit with the proper orthosis (brace) or prosthesis (artificial limb) for his or her individual needs. The orthotist then designs and fits the brace or prosthesis for the patient. Once the initial fitting is done, the orthotist or prosthetist continues to work with the patient, instructing him or her how to properly use the brace or prosthesis and conducting follow-up care throughout the course of the patient's disability or rehabilitation to ensure that the brace or prosthesis continues to fit properly and is properly used by the patient.

The O&P practitioner field is a relatively small one, with only about 2,300 certified practitioners available to serve the entire United States. The services of this industry are rehabilitative in nature, and typically reduce the length of stay for beneficiaries in costly inpatient settings, help restore mobility and ability to function unaided, making it possible for the O&P patient to return to useful work.

Orthotic and prosthetic services have been covered by Medicare since the inception of the program. However, in the Omnibus Budget Reconciliation Act of 1987 (OBRA'87), Congress adopted a drastic change in the reimbursement methodology for O&P services. OBRA '87 mandated a new fee schedule reimbursement methodology for O&P services. Medicare carriers are still struggling to implement the new payment methodology with regard to O&P services, and practitioners are still struggling to resolve errors and misunderstanding. Congress has directed the Health Care Financing Administration (HCFA) and the General Accounting Office (GAO) to conduct studies on the impact of the new payment methodology. These reports are not due to Congress until the end of this year.

III. THE ADMINISTRATION'S PROPOSALS FOR FISCAL YEAR 1991

The Administration has made the following budget proposals for FY'91 that would affect O&P practitioners.

First, the Administration has proposed to cap reimbursement for O&P practitioners at the median of all local fee schedules. Second, the Administration has proposed to cap local fee schedules that are at or above the national median cap would receive no payment update. Third, the Administration has proposed to give to Medicare carriers "prior authorization" authority as a method of controlling overutilization. Fourth, the Administration proposes to "give serious consideration" to competitive bidding demonstrations for durable medical equipment.

Before discussing these proposals, AOPA notes that this year, as in the past few years, budget proposals for durable medical equipment (DME) have been treated as including O&P notwithstanding the fact that these are completely different services. O&P is radically different from DME in that the service is completely personal and individual in nature and is far more a service than a product. In fact, the "product" element of the O&P practice (the brace or prosthesis) is only part of the total package of medical care provided by an O&P practitioner, and is not a "product" at all in the sense that it can be used again by another patient. Further, the O&P field is completely different from DME in that O&P has a defined body of clinical knowledge that requires baccalaureate and post-baccalaureate study to acquire, a core of certified practitioners, a well-established post-baccalaureate educational program in ten major universities, and significant and intensive professional involvement in the design and administration of treatment for patients who are often in acute and emergency medical need. Further, O&P services require the prescription of a physician, unlike DME products which can be acquired directly by the consumer. The subsuming of O&P within the completely different overall category of DME has had serious adverse affects on the O&P profession in the last several years. Most signifi-

cantly, this inappropriate melding of two very different medical services resulted in the application to O&P of the OBRA'87 fee schedule methodology without input, assessment and preparation from the O&P industry. The problem persisted in OBRA'89, when proposals for DME were (without explicit statement) held to cover O&P as well, causing policymakers to inadvertently consider action dramatically affecting the O&P industry without the benefit of cost estimates or Administration explanation as to how such proposals might specifically affect O&P practitioners.

Thus, the O&P industry's first request of policymakers is that this industry be treated and evaluated differently when Medicare budget reduction proposals are made. Such separation will result in better policy and more equitable treatment of the O&P industry. AOPA's specific comments on the Administration's budget proposals follow.

With regard to the national median limitation and no-update proposal, AOPA urges that Congress exclude O&P services from this limitation in order to avoid compromising the availability of O&P services. Estimates made by O&P educators using comparisons between statistics on the need for O&P rehabilitative services and the availability of O&P practitioners to provide these services show that there is already a shortage of such services in the United States. Particularly in light of the unresolved problems created by the OBRA'87 implementation, such payment cuts in limitations may well reduce the availability of O&P services, particularly in rural areas where such services are already scarce. Consequently, beneficiaries would have to travel sometimes hundreds of miles to obtain care. Where care was unavailable, Medicare and other government and societal costs would rise substantially due to longer hospitals stays for patients who could not be provided rehabilitative services quickly.

The threat of reduced availability of O&P services already exists due to reductions in Federal funds for O&P training—a highly costly program of study because of the substantial investment in clinical items and services necessary to provide this education. Without adequate educational funds, O&P practitioners cannot be trained, and thus, cannot enter the field to replace others who are leaving it due to death and retirement. This problem is particularly acute now because the average age of O&P practitioners is relatively high (in the 50s), meaning that practitioners are already leaving the field much faster than students can be trained to replace them.

AOPA also strongly urges that the Administration exclude O&P services from any proposal for competitive bidding. While it is difficult to comment on this proposal at all because no competitive bidding system or model is described in the Administration's plan, AOPA is confident in saying that competitive bidding would be entirely inappropriate for the O&P industry because every O&P procedure is different, and thus, no practitioner would be bidding on the same "thing." Indeed, the complete lack of fungibility of O&P procedures is demonstrated by the O&P coding system, which was developed by HCFA as a "add-on" or modular system, with each procedure described by a combination of several modular codes. Thus, there is no "basic" or "garden variety" O&P procedure, and it is virtually impossible to imagine how a competitive bidding model could be developed under such circumstances. Even if such a model could possibly be devised for O&P services, it would risk compromising the quality of care provided for physically compromised patients, each of whom needs a highly individualized service.

Finally, AOPA opposes the Administration's proposal to give carriers prior authorization authority. Carriers already have, and use, wide latitude to curb overutilization of O&P services through decisions as to whether a service is "medically necessary." Requiring prior authorization, on top of carriers' existing discretion on medical necessity, would constitute "overkill," delaying payment of claims and increasing Medicare's administrative costs without concomitant benefits.

AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on Finance,
Dicksen Senate Office Building.
U.S. Senate,
Washington, DC

Dear Chairman Bentsen: The American Society for Gastrointestinal Endoscopy (ASGE) would like to take this opportunity to comment on the Medicare recommendations contained in the President's Fiscal Year 1991 proposed budget. We request that this letter be made part of the official record of the hearings on this subject.

In recent years, the focus of health policy has often been simply reducing expenditures under the Medicare program. More often than not, these actions have been taken for short term budget purposes only, with little thought about long term health policy and the availability of quality medical services to the programs beneficiaries. We share with Congress a concern over unwarranted growth in services under the program; however, all too often the decision about volume is based on inadequate information. The assumption seems to be that a high number is always wrong and a low number is always preferable. Physicians know that frequently a low utilization of services indicates that inadequate medical care is being provided a community or population. A high or increasing volume of services does not necessarily mean that over-utilization is occurring.

Gastrointestinal endoscopy is a bet of services and technologies that has experienced dramatic growth in recent years and has become the subject of some concern to Members of Congress for this reason. ASGE is aggressively pursuing the refinement of existing medical care guidelines for gastrointestinal endoscopy and will be working on the development of new ones as the technology evolves in order to assure that the services being provided to patients, and paid for by the government, are necessary, appropriate, and of the highest possible caliber. In addition to ASGE's own efforts, we anticipate working closely with the Agency for Health Care Research and Policy in the development of medical care guidelines. ASGE believes that the development of such parameters of care and guidelines to assist the physician, the patient, and the payor will in the long run be the most effective way to deal with inappropriate medical expenditures.

ASGE is concerned, however, that the pressures of deficit reduction will continue to force cost cutting measures that are unrelated to the health care needs of the elderly patients served by Medicare. The President's budget proposes over $5 billion in Medicare Part A and Part B cuts. ASGE has reviewed these and is concerned that Medicare is being asked to bear too heavy a deficit reduction burden.

ASGE is particularly concerned that the Administration is again proposing reductions for certain procedures considered to be overvalued. Congress in 1989 added GI endoscopy to this list despite the fact that Dr. Hsiao and his research team at Harvard have not completed their review of gastroenterology. ASGE believes that no further cuts should be made until Dr. Hsiao completes his work and it can be analyzed to determine what the appropriate level of payment should be. We urge Congress not to take action on Medicare payments for these procedures until all the analysis has been completed.

ASGE recognizes the need to reduce Federal spending and fully understands the fact that the Medicare program must be a part of that. While we believe the President's proposals are too severe for further consideration by Congress, savings can be achieved if Congress chooses to simply freeze payments to physicians. Such a freeze, the use of the sequester, can achieve substantial program savings without major disruption to physicians and their elderly patients. We encourage Congress to take this approach rather than the ones recommended by the Administration.

ASGE is looking forward to working with Congress, the Health Care Financing Administration, and the Physician Payment Review Commission on the implementation of the new Medicare fee schedule, particularly as it affects gastrointestinal services. However, we are concerned by recent developments among Medicare Part B carriers to change substantially the rules of payment for GI endoscopy, treating it as a surgical service to be paid on a global fee basis and disallowing other charges associated with the provision of that care. These actions are very disruptive and will substantially complicate the implementation of the new fee schedule for gastroenterology. ASGE members are not only facing reductions in payments for these procedures because of deficit reduction laws, they are now faced with even heavier penalties because of arbitrary action by the Part B carriers. We have offered to meet with the Health Care Financing Administration in order to achieve a national and equitable policy; however, until that can be worked out our members are suffering unfair treatment at the hands of the Medicare program as it is being interpreted by the local carriers. We are very hopeful that we will be able to reach a satisfactory resolution with HCFA; however, we want to alert Congress to this problem.

On behalf of ASGE I appreciate the opportunity to submit these comments.

Sincerely,

DONALD O'KIEFFE, M.D., *Chairman,*
Committee on Government Relations.

AMERICAN SOCIETY OF HEMATOLOGY,
April 12, 1990.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on finance,
U.S. Senate,
Washington, DC

Dear Chairman Bentsen: The American Society of Hematology (ASH) is pleased to offer the following comments on the President's fiscal year 1991 budget proposals affecting the Medicare program. We request that this letter be made part of the official record of the March 22, 1990, hearings on Medicare before your committee.

In the Omnibus Budget Reconciliation Act of 1989, Congress adopted major changes to the way Medicare pays for physician services. In addition to creating a new Medicare fee schedule, designed to redistribute physician payments from procedures to evaluation and management services and from higher pay areas to lower pay areas, Congress also put in place Medicare Volume Performance Standards (MVPS) with the intent of reducing overall Part B growth. Implementation of these provisions is underway and the Health Care Financing Administration (HCFA) is committing a substantial portion of its time, energy and resources to meeting the deadlines established by Congress.

ASH is currently working with the team of William Hsiao, Ph.D., at Harvard University, on a review and analysis of the physician resources required in hematology services and procedures. Although many issues remain unresolved, we are confident that further work with Dr. Hsiao, the Physician Payment Review Commission (PPRC), HCFA, and Congress will assure that hematologists are reimbursed at appropriate levels and Medicare beneficiaries will continue to have uninterrupted access to hematologic services.

We believe this should be the guiding principle for implementation of the new fee schedule and the MVPS. That is, the implementing and regulating agencies must assure that their decisions do not limit appropriate access to health care services for Medicare beneficiaries. If the decisions of the government adversely affect the beneficiaries, then it is incumbent upon Congress to step in and correct the situation.

It is in that spirit that we express concern over the President's budget proposals for Medicare for fiscal year 1991. As has been the case so often in the past, the Medicare program is being asked to bear a major portion of the spending cuts required for deficit reduction purposes. We recognize that many Members of Congress have already expressed their concern over these proposed reductions and we heartily applaud those sentiments. Medicare has already been subject to substantial reductions, well documented by other analysts, and it stands to reason that those reductions cannot continue unabated without affecting beneficiaries' access to medical services. Therefore, we urge rejection of the President's Medicare budget proposals.

ASH members are very involved with the evaluation and management of disease and appreciate the recognition in the President's budget that reimbursement for these services should be increased. Nonetheless, the other cuts affecting both Part A and Part B of the program are so severe that our pleasure over this is greatly reduced by our concern over the magnitude and impact of these reductions. We realize that Congress will need to make deficit reduction decisions in Medicare and we ask only that those reductions be as small as possible. Cuts of the magnitude proposed by the President should not be accepted.

We are concerned that these proposals in the President's budget and the OBRA 1989 fee schedule ignore important realities of medical practice and will adversely affect hematology. We do not ask that you re-examine the new Medicare fee schedule right now, but we do believe that our concerns are shared by others and we would like to work on these problems with Congress prior to full implementation of the fee schedule.

We are particularly concerned that there is no differential in payment for bona fide services of a specialist. A patient seeing a specialist, such as a hematologist, seeks that physician out primarily because they want that extra measure of service that specialization can bring to a medical problem. To equate that extra level of specialized service with something less diminishes the physician's expertise and discourages the provision of complex services. The hematologist is often called upon to deal with extremely difficult cases, both in terms of diagnosis and treatment, and we are concerned that the extra measures of skill, time and effort will not be appropriately recognized under the new fee schedule.

One important factor affecting Federal medical care costs is the degree of uncertainty that exists in the provision of much medical care, including hematology. We applaud Congress' interest in the development of guidelines for care well as re-

search into the effectiveness of medical services. We believe that through the kind of research promoted by the Congressionally mandated Agency for Health Care Research and Policy, physicians will be able to reduce the degree of uncertainty, thereby reducing the level of inappropriate medical services. ASH supports the work of the Agency and encourages Congress to continue to support their work and the close involvement and participation of national medical specialty societies, such as ASH.

The American Society of Hematology also would like to comment on HCFA's implementation of the Clinical Laboratory Improvement Amendments of 1988. This new regulatory scheme, which would affect almost every physician, is a major undertaking that has profound implications for all patients, not just Medicare. We are deeply concerned that the regulations now under consideration are so stringent that easy access to laboratory services will become a thing of the past. That would be a major disservice to all patients, particularly the elderly, for whom an extra trip to a laboratory for testing can be a major inconvenience. We urge the Congress to monitor closely this situation to assure that this new regulatory scheme is not so burdensome that it forces physicians to eliminate safe, convenient laboratory services in their offices.

The American Society of Hematology supports the efforts of Congress to try to address the inequities in the current physician payment system as well as deal with problems of Federal budget deficit. We urge that Medicare not be the disproportionate source of budget savings as has been the case in the past. Likewise, we encourage Congress to oversee carefully the implementation of the new Medicare fee schedule. Unfortunately, the kinds of proposals contained in the President's FY 1991 budget can only make successful implementation more problematic. It would be indeed a shame if the new fee schedule were undermined by poorly designed deficit reduction measures.

The American Society of Hematology appreciates the opportunity to submit this testimony for the record and urges careful consideration of its recommendations.

Sincerely,

LOUIS M. ALEDORT, M.D., *Chairman,*
Committee on Practice.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

ASIM: PROPOSED BUDGET CUTS WOULD UNDERMINE PHYSICIAN PAYMENT LAW

WASHINGTON, DC.—The Bush administration's proposed 1991 budget, which calls for $2 billion in cuts in the Medicare Part B program, threatens to deny patients the benefits—such as improved access to care in rural communities—intended by Congress when it enacted physician payment reform, the American Society of Internal Medicine (ASIM) told the Senate Finance Committee today.

In addition, the panel should put the issue of increasing physician disillusionment with the Medicare program due to administrative burdens on its agenda, J. Leonard Lichtenfeld, MD, a Baltimore internist in private practice who testified for ASIM, told lawmakers.

"There is growing evidence that low levels of reimbursement, coupled with the growing administrative burdens-or hassle factors—associated with the Medicare program, may be beginning to harm access," Dr. Lichtenfeld said. "If enough physicians become completely disillusioned with the Medicare system, patient care will suffer."

The Senate Finance Committee should reject the $2 billion in budget cuts proposed by the administration, Dr. Lichtenfeld said. The committee also should oversee the administration's development of the new fee schedule's dollar conversion factor to make sure undervalued services and localities receive appropriate increases under the new system, he said.

In addition, Dr. Lichtenfeld recommended that lawmakers reject separate volume performance standards and conversion factor updates and direct the administration to desist from arbitrarily downgrading reimbursement for 1froutinett visits.

"If the administration has its way, the long-term benefits of physician payment reform will be sacrificed in order to attain immediate budget savings," Dr. Lichtenfeld said.

Dr. Lichtenfeld noted that the administration also could undermine physician payment reform with its calculation of the dollar conversion factor, which is needed to turn the relative value scale into an actual fee schedule.

The administration, in an October 1989 report to Congress, suggested that it intends to assume that volume will increase substantially under the new physician fee schedule, thereby justifying a much lower dollar conversion factor.

"The manner in which the initial dollar conversion factor is calculated will determine if the new system truly improves reimbursement for undervalued cognitive-or evaluation and management—services, or if it instead perpetuates and exacerbates existing inequities," Dr. Lichtenfeld said.

Dr. Lichtenfeld voiced concerns about separate volume performance standards. The physician payment reform legislation requires the secretary of health and human services to propose separate volume performance standards for surgery and other services.

Ideally, Dr. Lichtenfeld said, there should be one volume performance standard and one conversion factor for all physician services. If separate standards are instituted, he said, "the result will be that, instead of working together to identify ways to appropriately control the volume of all physician services, each specialty will try to shift the problem—and blame—to someone else."

The Senate Finance Committee also should address the problems being created by the widespread "downcoding" of evaluation and management services, Dr. Lichtenfeld said. Internists nationwide are finding that, when they submit Medicare claims for more extensive visits, those claims are routinely "downcoded" to reflect lower levels of care, he said.

"Mandating a fee schedule that pays more for each level of service does no good if the Medicare program can simply offset those increases by routinely downcoding those services to a lower level of care," Dr. Lichtenfeld said.

STATEMENT OF THE AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS (ASPRS)

The American Society of Plastic and Reconstructive Surgeons (ASPRS) appreciates the opportunity to present comments on the proposed fiscal year 1991 Medicare budget.

ASPRS shares several concerns of the American College of Surgeons (ACS) and the American Medical Association (AMA). Initially, it is our opinion that additional policy changes, such as the proposed Medicare Part B reductions, should not occur before the implementation of the recently-approved Resource Based Relative Value Scale and other policy decisions relating to Medicare payment reform. It is ASPRS' opinion that those involved in the decisionmaking process must consider the possible long-term effects of meeting short-term budgetary goals.

In addition, ASPRS shares the ACS' concerns regarding the following proposals:

- An MEI update should be established for all physician services—not only those provided by primary care physicians, as proposed.
- ASPRS understands that many changes are still occurring with finalizing the RBRVS. Thus, in our opinion, it will be necessary to reevaluate those procedures which have been labled as "over-valued" so as to reflect a well-stablized, integrated system.
- We believe that further thought needs to be given to payment procedures for assistance-at-surgery. In certain cases, an assistant-at-surgery decreases the amount of risk to the patient and, therefore, preserves the patient's access to quality care. When the operating surgeon orders the services of an assistant, we believe that reasonable compensation should be provided for the assistant who is a physician.
- We also agree with the ACS in that across-the-board fee reductions, applicable to all physician's services, would be favorable for the upcoming period—prior to implementation of the new payment plan. Once again, we feel strongly that the implementation of the methodology under the new Medicare payment reform plan should not be underminded by proposing various budgetary cuts, including those reductions proposed for Medicare Part B services.

ASPRS appreciates the opportunity to express its views regarding the FY 1991 budget issues relating to physician payments under Part B of the Medicare Program.

AMERICAN UROLOGICAL ASSOCIATION, INC.,
Baltimore, MD, April 12, 1990.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on Finance

U.S. Senate,
Washington, DC.

Dear Chairman Bentsen: On behalf of the members of the American Urological Association, I would like to offer the following comments on the Medicare budget proposals contained in the President's Fiscal Year 1991. As has been the case for the last several years, the Administration is proposing substantial cutbacks in spending under the Medicare program, this year suggesting approximately $5.5 billion in reductions. AUA believes that continued cuts of this magnitude in the Medicare program cannot be allowed. While recognizing the need to achieve deficit reduction, AUA believes that cutting the budget must be balanced against preserving the success of the Medicare program.

Medicare was adopted in 1965 in order to assure that the elderly and disabled would not have financial barriers to receiving medical care equivalent to that available to anyone else. For many years, Medicare and the government have kept that promise alive. However, eight years of budget cutting have resulted in a continued erosion of funds available for both Parts A and B of Medicare. AUA does not dispute the fact that some expenditures may exceed what is required; however, we do believe that putting the Medicare budget under the knife one more time is ill advised.

We are particularly concerned that the President's budget proposals affecting Part B of Medicare single out surgeons for much of the deficit reduction. For example, the President's budget proposes cuts in the payment for assistants at surgery and in global surgical payments. The rationale for either proposal is unsound. It makes no sense to tell a physician if he or she needs an assistant that payment for the assistant is going to have to come out the surgeon's own pocket. That is indeed a disincentive to assuring that the appropriate surgical team is pulled together. AUA recommends that medical specialty societies work with the Health Care Financing Administration (HCFA) to identify those procedures where the presence of an assistant is always required, those where the presence of an assistant is never necessary and for the remaining cases develop guidelines to help the carriers determine if payment for an assistant is appropriate. We believe that such an analysis would reduce overuse of surgical assistants while not jeopardizing their use when medically necessary.

The justification in the President's budget for reducing the payment for the surgical bundle is that lengths of stay in hospitals are shorter for Medicare patients. Thus the physician may need to make fewer hospital visits then was the case some years ago. This budget proposal simply ignores reality. First of all, the surgeon's global fee covers care both in and outside the hospital. Simply because patients may be leaving the hospital somewhat earlier does not mean they do not continue to receive medical care. The locus of the care may change from the hospital to the rehabilitation unit or to a physician's office, but the need for follow up care after surgery has remained the same. In fact, many physicians are seeing surgical patients of a greater age and complexity than once was the case due to advancements in medical technique. These individuals actually require more skilled follow-up care than did their younger, more healthy counterparts. A reduction in the global payment for surgery should be rejected by the Congress.

Once again the Administration is looking to procedures designated as "overvalued" by the Congress for additional reductions. AUA has been critical of the methodology for making these determinations and we still believe that the science of determining if a procedure is or is not over-valued is very rudimentary. The President's proposal is particularly frustrating to urologists who have been assured that, under the new Medicare fee schedule, payment for their evaluation and management services would rise to help compensate for any losses due to reductions in reimbursement for surgery. However, we are facing a proposed third cut for payment for the major surgical procedure in urology, TURP, without any reevaluation of our evaluation and management services. Payments in California have already been reduced 8–13%, in Ohio 7–8%, and in Texas, 7% by OBRA '89. The President's proposal would increase these reductions, with few offsetting adjustments. We urge Congress to reject the cut in overvalued procedures suggested in the President's budget.

We are also concerned that further erosions in payment may skew the new Medicare fee schedule in unintended ways, thus rendering the fee schedule even less likely to have beneficial The results for physicians and the patients they serve.

AUA recognizes that Congress must make some adjustment in Medicare in order to meet its deficit goals. We believe that across-the-board freezes or small reductions (such as sequestration) to be shared by all physicians are the appropriate way to go. Large amounts of savings can be generated, no one group is disadvantaged more than another and all physicians share in the reductions that are required. We con-

sider this a much less disruptive policy than the ones contained in the President's budget.

Ultimately Congress will have to deal with continued growth in the Medicare Part B program. AUA is committed to effectiveness and outcomes research and is now engaged in a major study on TURP and other treatments for BPH with Dr. John Wennberg. Likewise, we have made a major commitment to the development of guidelines for medical care and are working with the Agency for Health Care Research and Policy to develop appropriate guidelines for the treatment and management of BPH. We believe that this type of research and guideline development is the appropriate way to deal with volume issues while simultaneously assuring higher standards of medical care. We urge Congress' continued support for the Agency and its programs.

The AUA appreciates the opportunity to submit these comments. I request that they be made a part of the official hearing record on budget reconciliation.

Sincerely,

GREGORY A. SLACHTA, M.D., *Chairman,*
Socioeconomic Committee.

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC), which represents all of the nation's medical schools, 92 faculty societies, and over 350 major teaching hospitals that participate in the Medicare program, welcomes the opportunity to provide testimony on the Administration's Fiscal Year 1991 budget proposals for Medicare. In Federal fiscal year 1988, non-Federal members of the AAMC's Council of Teaching Hospitals (COTH) accounted for nearly 2 million, or 18 percent, of Medicare inpatient discharges.

The Administration's budget proposals would reduce the growth in Medicare program expenditures by $5.5 billion in FY 1991. Payments for hospital inpatient services under Medicare Part A provisions would be reduced by almost $3.4 billion, representing 62 percent of the proposed savings in the Medicare program. While all of the Administration's health care budget proposals are of interest to hospitals, three proposals to change Medicare payments are of special concern to teaching hospitals:

- the proposed reduction in the Medicare indirect medical education (IME) adjustment from its current 7.7 percent for each 0.1 increase in the ratio of residents-to-beds to 4.05 percent;
- the proposed change in Medicare direct medical education payments from a per resident payment that includes the full range of allowable costs to a per resident amount derived only from residents' salaries and paid differentially to hospitals based on a trainee's specialty; and
- the proposed ten percent "across the board" reduction in hospital outpatient department payments.

Each of these proposed changes would result in a substantial reduction in Medicare revenues for teaching hospitals. Of the $3.4 billion proposed reduction in FY 1991 Medicare expenditures for inpatient hospital services, over $1.2 billion, or nearly 36 percent, would be achieved by cutting the indirect medical education adjustment and direct medical education payments to teaching hospitals. Proposed reductions in these two payments to teaching hospitals account for 22 percent of the total proposed savings in the Medicare program budget. Collectively, the resulting decrease in revenues caused by these proposals would seriously threaten the financial stability of teaching hospitals, affecting access to care and quality of care received by Medicare beneficiaries and other patients.

INDIRECT MEDICAL EDUCATION ADJUSTMENT

Teaching hospitals provide an environment for biomedical research and medical education, in addition to producing primary, secondary, and tertiary patient care. Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education adjustment in the Medicare Prospective Payment System (PPS). However, the "indirect medical education" adjustment is mislabeled and its purpose is frequently misunderstood. While its label has led many to believe this adjustment to the Diagnosis Related Group (DRG) prices compensates hospitals solely for education, its purpose is much broader. Both the Senate

Finance and House Ways and Means Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, Number 98–23, March 11, 1983 and House Ways and Means Committee Report, Number 98–25, March 4, 1983).

The Administration's proposal to reduce the IME adjustment from its current 7.7 percent for each 0.1 increase in the ratio of interns and residents-to-beds to 4.05 percent would substantially harm the financial viability of teaching hospitals. AAMC analysis of hospital financial data for 1986 through 1989, provided by 46 members of the AAMC's Council of Teaching Hospitals who are listed at the end of this testimony, suggests any reduction in the IME adjustment will substantially harm teaching hospitals. PPS margins have dropped dramatically during this period (Table 1). Average PPS margins for these hospitals fell from 20.7 percent in 1986 to 4.5 percent in 1989. Of the 46 hospitals in Table 1, 32 (70 percent) reported lower PPS margins in 1989 compared to 1988. While no hospital had a negative PPS margin in 1986, by 1989 sixteen hospitals had PPS margins less than zero.

For the analysis in this testimony, PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, IME payment and outlier payments) less Medicare inpatient operating costs, divided by PPS revenue. This definition excludes Medicare revenue and costs associated with capital, direct medical education, PPS exempt patient care units, and some other categories. In most cases, payments for these cost components are made on a cost or less-than-cost reimbursement basis, so the margin for these items is generally negative. Therefore, the margins for Medicare inpatient beneficiaries are less than the PPS margins shown in this analysis.

Policy actions such as changes in future payment rates are based on historical data and reflect assumptions about current year impact. It is important to realize that the Administration's FY 1991 budget proposals affecting teaching hospitals are based on assessments of hospital financial data from the fifth-year of PPS (1988). Hospitals are now experiencing the seventh-year of PPS (1990), so PPS margins calculated from 1988 or 1989 data do not reflect the current financial status of teaching hospitals. PPS margins for 1990 are expected to be lower than 1989 margins.

The AAMC strongly supports the consideration of overall hospital financial performance, as measured by total margin, in determining the level of the IME adjustment. For the 46 COTH members, the average total margin, which includes all patient care operations, government appropriations, and other income from investments and philanthropy, declined from 6.0 percent in 1986 to 3.4 percent in 1989. Total margins have remained consistently lower than PPS margins during these years because factors other than PPS payments, such as uncompensated care, affect the overall financial performance of teaching hospitals. Another data source, ProPAC analysis of Medicare Cost Report Files from the Health Care Financing Administration, indicates that in PPS year five, PPS operating margins for major teaching hospitals were 11.3 percent, while the total margins for those same hospitals were -0.7 percent.

Table 2 uses 1989 data to demonstrate the impact of various types of PPS payments on 46 medical center hospital margins and the effect of cutting the IME adjustment to 4.05 percent as proposed in the Administration's budget. On average, PPS margins calculated with the DRG and outlier payments and the current IME adjustment, but without the disproportionate share (DSH) adjustment, which partially compensates hospitals with significant shares of low-income patients, are close to zero. The IME adjustment makes a significant contribution to reducing the large losses, from -34.5 percent to -0.8 percent, that would result if payment were limited to the DRG rate plus outliers. The addition of the DSH payment to the margin calculation moves the average PPS margin to 4.5 percent. If the IME adjustment had been reduced from 7.7 percent to 4.05 percent as proposed by the Administration, the average PPS margin would have fallen from 4.5 percent to negative -7.8 percent, a reduction of over 12 percentage points. Once again, it is important to remember that the inclusion of capital and direct medical education, cost components that are paid by Medicare on a cost or less-than-cost reimbursement basis, the margin calculation would have resulted in an even lower Medicare inpatient margin.

The IME and DSH adjustments constitute a significant portion of total PPS payments, but in the absence of a DSH payment these hospitals tend to have negative

PPS margins at the current IME adjustment level. Table 3 shows that five of the six hospitals receiving no DSH payment reported negative PPS margins in 1989. It should also be noted, however, that a high percentage of IME and DSH payments relative to the total payment does not necessarily guarantee a large positive margin.

The early years of the prospective payment system are now over, and the current system is significantly different from the system that produced headlines about teaching hospital profitability. The hospital-specific payment component which was overstated is no longer used to determine payments and the IME adjustment has been substantially reduced without the addition of a severity adjustment. Finally, the annual increases in DRG prices have been lower than the increases in goods and services purchased by hospitals. As a result, teaching hospital PPS margins are declining and are expected to be even lower in 1990. The adjustments, including the IME adjustment, will be increasingly important to teaching hospitals.

Recent analyses of the overlapping relationship between the IME and DSH adjustments have led some policy makers to conclude that teaching hospitals would not be harmed by a reduction in the IME adjustment. A reduction in the indirect medical education adjustment affects all teaching hospitals, reducing the margins for institutions regardless of their low-income patient share. AAMC analysis suggests that any reduction in the IME adjustment would harm major teaching hospitals, particularly those institutions that do not receive significant DSH payments. Once again, five of the six hospitals receiving no DSH payment reported negative PPS margins in 1989.

The indirect medical education payment is an important equity factor in the Medicare prospective payment system, compensating teaching hospitals for the severity of their patients' illnesses, the scope of services provided, and the impact of educational programs on hospital operating costs. Teaching hospitals will be "hard hit" by a reduction in the IME adjustment, particularly since margins for both Medicare and non-Medicare cases are dropping rapidly. Therefore,

the Association of American Medical Colleges firmly opposes any proposed reduction in the IME adjustment below its current level of 7.7 percent for each 0.1 increase in a hospital's ratio of residents-to-beds.

DIRECT MEDICAL EDUCATION COSTS

In addition to providing medical care to individual patients, teaching hospitals provide the resources for the clinical education of physicians, dentists, nurses, and allied health professionals.

To provide this experientially-based clinical training, hospitals incur educational costs related to patient care. These added costs include resident stipends and benefits, salaries and benefits for faculty supervision of trainees, classroom space, supplies, clerical support, and allocated overhead. Medicare has historically shared in the costs of these approved education activities on a reasonable cost basis. Not to be confused with the purpose or methodology of the indirect medical education adjustment in the prospective payment system, the Medicare program makes a separate payment to teaching hospitals for its share of allowable direct health professions education costs.

The passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (P.L. 99–272) in 1986 changed the method of payment and placed restrictions on Medicare reimbursement for physicians in graduate training (residents). Intended to limit the amount of direct costs that could be "passed through" to the Medicare program, COBRA requires the calculation of a hospital-specific per resident amount, based on 1984 costs and updated to adjust for inflation. Each hospital's per resident amount is determined by dividing its allowable costs by its number of residents at the hospital during the year. The per resident amount is then updated for inflation and multiplied by the full-time equivalent (FTE) of interns and residents in the hospital complex in the cost reporting period. Residents are weighted at 1.0 FTE for the initial residency period plus one year, not to exceed a total of five years. Beyond either of these two limits residents, will be weighted at .5 FTEs. These per resident payments are effective retroactively to July 1, 1985. Medicare's share of the aggregate payment amount is based on the ratio of Medicare inpatient days to total inpatient days. Although COBRA limits payment of allowable direct medical education costs, it still acknowledges the historical scope of direct medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

Teaching hospitals have yet to experience the impact of the COBRA-legislated changes for direct medical education costs, because final regulations were published only six months ago (September 29, 1989, 54 *Federal Register* 40285) and have not

been implemented. Final guidelines for auditing hospitals' per resident amounts have been issued only recently (February 12, 1990) and most hospitals have yet to be audited.

The Administration's proposal as set forth in the FY 91 budget document is as follows:

> This proposal would establish a per resident payment derived from the national average of FY 1987 salaries paid to the residents updated by the CPI. Primary care residents would be weighted at 180 percent of the per resident payment amount, non-primary care residents in their initial residency period would be weighted at 140 percent, and non-primary care residents beyond the initial residency period would be weighted at 100 percent. This proposal would decrease the present diversity in GME payments that has resulted from historical patterns in hospital accounting.

For the vast majority of the nation's major teaching hospitals this proposal will reduce revenues intended to cover the costs incurred by hospitals in providing medical education. The proposal further narrows the historical recognition of the broad scope of direct medical education costs by reducing payment for the costs of supervisory faculty salaries, and allocated overhead, certainly resulting in decreased funding.

The Administration's proposal to make higher payments to hospitals based on residents in primary care specialties and on length of training is apparently intended to serve as an incentive for hospitals to offer more primary care residency positions. While the AAMC supports efforts to increase primary care training, the Association believes that the Administration's proposal to make differential payments for direct medical education costs based on specialty is misguided and is based on two incorrect assumptions. First, the proposal inaccurately assumes that there is a shortage of primary care residency positions. Data from the National Residency Matching Program (NRMP) show that of the 9.1% first-year residency positions offered in internal medicine, pediatrics and family practice in 1989, only 59.9 percent were filled by graduates of U.S. medical schools. If graduates of other medical schools are counted as part of the matching program, 79.4 percent first-year residency positions were filled in these three primary care specialties, leaving about 20 percent of the presently existing positions unfilled. Thus, the problem is not a shortage of primary care positions.

The proposal also assumes a relationship between medical student choice of specialty and level of hospital payments. Medical students' failure to choose primary care residency training is not based on the unavailability of residency slots in these specialties or on the level of hospital payment. Their reasons for choosing specialties other than primary care are complex and only partly understood, but are based on a combination of personal, professional and geographic factors. While strongly supporting more individuals entering primary care, the AAMC does not believe this result can be achieved by manipulating hospital reimbursement. On the contrary, only personal incentives (loan forgiveness, bonuses, etc.,) aimed at the individual will be successful in inducing more U.S. graduates to enter the primary care fields.

The Administration's proposal to change payments for graduate medical education would certainly result in reduced payment for the costs of supervisory faculty salaries. ass support for supervising faculty would have a significant adverse effect on the quality of both patient care and residency training programs in the nation's teaching hospitals. Graduate medical education is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Residents are major contributing members of the professional team that care for patients and ample supervision is necessary to monitor appropriately residents' development in an environment of rapidly changing practice patterns. Recent public and media attention to the issues of residents' supervision and working hours has led to state governmental as well as voluntary accreditation efforts to set minimum requirements for supervision and to restrict residents' working hours. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated. The AAMC believes that third-party payers, including Medicare, must support their proportionate share of the costs of supervision and other related educational costs to help ensure high quality patient care, and to preserve the high quality of residency programs. Therefore,

> **the Association of American Medical Colleges firmly opposes any legislative changes in the current payment system for direct graduate medical education costs.**

HOSPITAL OUTPATIENT DEPARTMENT PAYMENTS

By enacting the Medicare prospective payment system in 1983 as a way to pay hospitals for the cost of inpatient services, the Federal Government intended to slow the growth in health care expenditures and to give hospitals a financial incentive to provide services efficiently. One of the ways in which hospitals responded to these incentives was to shift the provision of some traditionally inpatient services to the outpatient setting. As a result, utilization of outpatient services has increased. In recent years Congress has recognized the need to control the growth in Medicare outpatient expenditures and has modified the traditional cost-based reimbursement of hospital outpatient services in anticipation of a fully prospective payment system for all outpatient services. Some prospective pricing methods of payment have already been mandated for clinical laboratory services, many outpatient surgical services, and a number of outpatient diagnostic services. These different methods of payment constitute an interim step in the reform of the Medicare outpatient payment system.

While the details of a completely prospective payment system for outpatient services are still under consideration, the Administration has proposed a ten percent "across-the-board" reduction in Medicare payments for certain hospital outpatient services, beginning in FY 1991. The Administration has offered no rationale or empirical evidence for the proposed ten percent reduction in hospital outpatient payments other than the need to control the growth in expenditures for Medicare hospital outpatient services. The ProPAC is conducting a congressionally mandated study of hospital outpatient payments under PPS. The report is due to Congress by July I, 1990, and a follow-up report with alternative methods for payment of outpatient services is due March 1, 1991.

The burden of this arbitrary proposed policy would fall disproportionately on teaching hospitals, potentially affecting access to services and quality of care available to Medicare beneficiaries and other individuals. Many teaching hospitals, located primarily in urban areas, have established large clinics and primary care services to meet neighborhood health care needs and to provide a well-rounded educational experience for medical students and residents. Major teaching hospitals are larger and have more outpatient and emergency visits than most community hospitals. In 1987, non-Federal members of the Council of Teaching Hospitals provided 52 million non-emergency outpatient visits. Although accounting for only 6 percent of the nation's hospitals, COTH members had 31 percent of all non-emergency outpatient visits.

Efforts are underway to replace the present Medicare payment system for hospital outpatient services with a fully prospective payment system. The Administration's proposal to reduce certain hospital outpatient payments by ten percent, apparently proposed as a simple way to slow the growth in Medicare outpatient payments, has no empirical basis. If hospitals are being inappropriately compensated for the provision of outpatient services, refinements to the payment system should be made on the basis of empirical study. A short-sighted, poorly conceived policy to reduce payments by some arbitrary amount could have serious implications for access to and quality of hospital outpatient services. Therefore,

the Association of American Medical Colleges firmly opposes any reduction in Medicare payments for hospital outpatient services.

CONCLUSION

The Medicare program has been a frequent target for proposed reductions in Federal spending, and for the past several years has provided a substantial share of the budget savings needed by Congress to reach budget targets. Within the Medicare budget, cuts in the direct medical education payment and the indirect medical education adjustment are easy targets because their education labels are perceived as inconsistent with a patient services program.

The Administration's FY 1991 Medicare budget proposals for inpatient hospital services would have a significant adverse affect on teaching hospitals. Nearly 36 percent of the $3.4 billion proposed reduction in payments for inpatient hospital services would come from decreased direct medical education payments and lower indirect medical education payments to teaching hospitals. If Congress adopts additional proposed reductions affecting all hospitals, the nation's teaching hospitals will experience even greater financial distress. Recent data have shown that teaching hospitals' average total financial margins are lower than any other type of hospital and these margins continue to decline. The financial success or failure of hos-

pitals could affect access to care and quality of care received by Medicare beneficiaries and other patients.

Teaching hospitals are an important component of the nation's health care system, providing all levels of patient care services, including tertiary care; serving as primary sites for the clinical education of health manpower, including physicians, dentists, nurses, and allied health professionals; and providing the environment for the conduct of clinical research. The current emphasis on reexamining national policies in light of limited public resources places teaching hospitals and their vital activities at risk if their special roles and nature are not appreciated. A reduction in the IME adjustment, or in payments for direct medical education costs or hospital outpatient services, would constitute a severe economic hardship for teaching hospitals. National policy on health care delivery and payment must recognize the unique characteristics and diversity of teaching hospitals so that their fundamental missions can be preserved.

Table 1.—PPS MARGINS IN SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986--FY 1989 RANKED BY FY 1989 PPS MARGIN

[In percent]

Hospital	PPS Margins				Total margin FY 89
	FY 86	FY 87	FY 88	FY 89	
A	30.8%	3.5%	24.8%	37.1%	3.8%
B	28.6	21.2	22.8	36.7	−0.8
C	22.5	29.1	33.5	34.4	7.4
D	25.4	28.4	31.7	30.4	13.6
E	36.0	25.1	29.2	28.3	−1.7
F	39.3	11.9	13.6	27.8	−4.0
G	27.1	13.7	14.8	22.0	−0.04
H	24.6	13.8	15.7	22.0	3.6
I	32.9	16.5	20.8	19.7	6.1
J	31.8	22.7	16.7	18.5	3.2
K	23.5	15.9	17.0	16.6	4.7
L	14.9	14.4	18.4	16.3	6.9
M	23.1	17.1	13.8	15.2	2.4
N	7.7	9.0	24.3	14.7	0.0
O	24.2	28.3	14.5	14.7	3.6
P	25.3	22.0	17.9	14.7	5.5
Q	14.4	13.8	−6.1	12.3	−1.2
R	24.5	21.6	16.4	10.0	2.3
S	17.8	10.8	2.8	9.2	−2.9
T	17.6	13.5	16.0	8.6	5.8
U	33.6	26.4	27.5	7.8	2.4
V	12.3	7.1	5.4	7.8	1.5
W	25.1	19.5	12.5	7.8	7.3
X	26.8	15.3	9.8	6.7	10.7
Y	9.0	19.1	17.1	6.6	8.3
Z	5.9	16.9	4.1	6.5	0.8
AA	27.3	17.9	17.8	6.4	5.3
BB	20.7	7.0	−0.7	3.5	5.9
CC	12.7	10.7	11.3	2.6	1.9
DD	28.9	14.2	1.4	1.0	3.5
EE	23.6	9.9	5.7	−2.1	3.5
FF	2.7	−4.8	−1.7	−2.9	5.3
GG	12.8	19.9	7.9	−3.0	1.7
HH	16.7	10.7	5.1	−3.5	2.6
II	18.1	25.9	5.8	−4.1	−1.0
JJ	22.8	5.6	19.7	−4.5	−0.7
KK	18.8	15.2	8.8	−4.6	−0.6
LL	23.4	15.6	10.2	−6.8	2.7
MM	14.9	11.4	7.7	−8.9	3.3
NN	35.0	32.3	−3.6	−9.4	3.2
OO	6.6	2.1	−7.3	−9.6	13.6
PP	20.0	14.8	4.6	−11.3	4.5
QQ	11.7	6.5	−9.2	−11.8	5.1

Table 1.—PPS MARGINS IN SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986—FY 1989 RANKED BY FY 1989 PPS MARGIN—Continued

[In percent]

Hospital	PPS Margins				Total margin FY 89
	FY 86	FY 87	FY 88	FY 89	
RR	18.7	17.2	10.8	−16.6	8.1
SS	28.1	11.1	3.9	−19.2	4.9
TT	20.9	16.1	9.3	−28.3	5.5
Median	23.0	15.5	11.9	7.3	3.5
Average (weighted)	20.7	16.1	10.6	4.5	3.4

Source: Association of American medical colleges. FY 1989 COTH Survey of hospitals' financial and general operating data.

Table 2.—CONTRIBUTION OF PPS PAYMENTS TO SELECTED ACADEMIC MEDICAL CENTER HOSPITALS' PPS MARGINS: FY 1989 RANKED BY DRG PAYMENT, OUTLIERS, DSH AND IME @ 4.05 PERCENT

[In percent]

Hospital	DRG Payment less operating costs	Payment with outliers only	Payment with outliers and IME only	Payment with outliers, IME and DSH	Payment with outliers and DSH and IME @ 4.05 percent
B	−14.5%	−5.1%	23.6%	36.7%	29.0%
A	−9.9	0.0	29.3	37.1	28.1
C	−8.5	−0.7	23.6	34.4	27.1
D	−12.2	−7.5	21.3	30.4	21.5
F	−36.3	−25.3	12.8	27.8	17.9
E	−21.2	−14.4	22.4	28.3	16.3
G	−18.6	−12.5	9.4	22.9	15.2
I	−19.3	−12.6	11.1	19.7	11.6
H	−23.0	−18.9	19.0	22.0	8.4
J	−29.1	−18.3	13.0	18.5	7.5
M	−38.9	−19.0	7.9	15.2	5.8
N	−20.1	−13.9	10.3	14.7	5.6
K	−40.6	−28.6	6.6	16.3	5.1
O	−35.3	−21.7	8.4	14.7	4.1
L	−31.7	−24.7	11.5	16.6	4.0
P	−28.9	−20.1	10.8	14.7	3.2
Q	−42.9	−29.5	1.5	12.3	2.4
T	−26.1	−16.2	0.5	7.8	1.5
S	−24.3	−14.8	6.4	8.6	0.1
R	−29.9	−24.8	6.5	10.0	−1.9
X	−19.9	−15.6	6.5	6.5	−2.8
V	−40.3	−27.9	3.8	7.8	3.9
U	−56.3	−38.8	3.6	9.2	−5.3
Y	−50.3	−32.0	2.0	6.6	−5.9
W	−50.5	−40.2	0.9	7.8	−6.2
CC	−51.7	−33.7	−1.5	2.6	−9.4
Z	−53.5	−44.4	2.3	6.7	−9.6
AA	−57.7	−47.8	0.0	6.4	−9.6
DD	−49.5	−33.3	−1.7	1.0	−11.4
BB	−60.0	−38.6	1.1	3.5	−11.5
PP	−38.0	−25.2	−17.7	−11.8	−14.9
EE	−53.2	−44.7	−8.1	−2.1	−15.4
FF	−56.7	−42.6	−6.8	−3.0	−16.5
II	−49.9	−34.9	−4.6	−4.6	−17.1
NN	−69.0	−49.9	−23.9	−9.4	−18.1
GG	−67.9	−49.5	−7.3	−2.9	−18.3
JJ	−112.3	−61.4	−15.7	−4.1	−18.6
HH	−77.9	−61.5	−14.1	−3.5	−18.7
KK	−86.2	−64.3	−17.7	−4.5	−19.0
MM	−47.7	−33.0	−8.9	−8.9	−19.2

Table 2.—CONTRIBUTION OF PPS PAYMENTS TO SELECTED ACADEMIC MEDICAL CENTER HOSPITALS' PPS MARGINS: FY 1989 RANKED BY DRG PAYMENT, OUTLIERS, DSH AND IME @ 4.05 PERCENT—Continued

[In percent]

Hospital	DRG Payment less operating costs	Payment with outliers only	Payment with outliers and IME only	Payment with outliers, IME and DSH	Payment with outliers and DSH and IME @ 4.05 percent
OO	−49.6	−35.5	−9.6	−9.6	−20.7
LL	−71.1	−53.5	−11.8	−6.8	−22.0
QQ	−61.4	−51.1	−11.3	−11.3	−27.2
SS	−59.6	−43.8	−19.2	−19.2	−29.8
RR	−93.3	−79.6	−27.4	−16.6	−33.6
TT	−110.2	−91.0	−35.1	−28.3	−48.1
Median	−45.3%	−30.8%	1.8%	7.3%	−5.6%
Average (weighted)	−47.5%	−34.5%	−0.8%	4.5%	−7.8%

Source: Association of American medical colleges. FY 1989 COTH survey of hospitals' financial and general operating data.

Table 3.—INDIRECT MEDICAL EDUCATION AND DISPROPORTIONATE SHARE PAYMENTS AS PERCENTAGES OF TOTAL PPS PAYMENTS: FY 1989 RANKED BY FY 1989 PPS MARGIN

[In percent]

[illegible]	IME as percent of total PPS Payment	DSH as percent of total PPS payment	DSH and IME as percent of total PPS payment	FY 89 PPS margin	FY 89 IRB ratio
A	26.1%	11.0%	37.1%	37.1%	0.6979
B	22.6	17.2	39.8	36.7	0.6793
C	20.7	14.2	34.8	34.4	0.4772
D	23.7	11.7	35.3	30.4	0.5930
E	29.7	7.6	37.3	28.3	0.6685
F	25.2	17.2	42.4	27.8	0.7484
G	16.7	14.0	30.7	22.0	0.2981
H	30.7	3.6	34.4	22.0	0.7590
I	19.0	9.7	28.7	19.7	0.3846
J	24.8	6.4	31.2	18.5	0.6031
K	27.4	5.7	33.1	16.6	0.6896
L	24.5	10.4	34.9	16.3	0.6033
M	20.9	7.9	28.8	15.2	0.4423
N	20.2	4.9	25.1	14.7	0.4127
O	23.0	6.9	29.9	14.7	0.5672
P	24.6	4.3	28.9	14.7	0.5299
Q	21.3	10.9	32.3	12.3	0.4205
R	24.1	3.7	27.8	10.0	0.5699
S	28.8	5.8	34.6	9.2	0.7104
T	18.1	2.3	20.4	8.6	0.3143
U	23.8	4.2	28.0	7.8	0.4586
V	13.3	7.4	20.7	7.8	0.5379
W	27.3	6.9	34.2	7.8	0.6770
X	30.9	4.5	35.4	6.7	0.7756
Y	24.6	4.7	29.3	6.6	0.5529
Z	19.2	0.0	19.2	6.5	0.4497
AA	30.3	6.3	36.7	6.4	0.8088
BB	28.0	2.4	30.4	3.5	0.6307
CC	23.1	4.1	27.2	2.6	0.4865
DD	23.1	2.6	25.7	1.0	0.4722
EE	23.9	5.5	29.4	−2.1	0.4900
FF	27.1	4.1	31.1	−2.9	0.5981
GG	24.2	3.6	27.8	−3.0	0.5063
HH	26.6	9.3	35.9	−3.5	0.6577
II	25.5	10.0	35.5	−4.1	0.5634

Table 3.—INDIRECT MEDICAL EDUCATION AND DISPROPORTIONATE SHARE PAYMENTS AS PERCENTAGES OF TOTAL PPS PAYMENTS: FY 1989 RANKED BY FY 1989 PPS MARGIN—Continued

[In percent]

Hospital	IME as percent of total PPS Payment	DSH as percent of total PPS payment	DSH and IME as percent of total PPS payment	FY 89 PPS margin	FY 89 IRB ratio
JJ	25.2	11.2	36.4	−4.5	0.6087
KK	22.4	0.0	22.4	−4.6	0.4709
LL	25.9	4.5	30.4	−6.8	0.5776
MM	18.1	0.0	18.1	−8.9	0.3277
NN	15.3	11.7	27.0	9.4	0.2774
OO	19.1	0.0	19.1	−9.6	0.3474
PP	26.3	0.0	26.3	−11.3	0.5551
QQ	5.7	S.0	10.7	−11.8	0.0993
RR	26.6	8.5	35.1	−16.6	0.6483
SS	17.1	0.0	17.1	−19.2	0.3407
TT	27.8	5.0	32.8	−28.3	0.6564
Median	24.2%	5.6%	30.4%	7.3%	0.5593
Average (weighted)	23.7%	5.2%	29.0%	4.5%	H.A.

Source: Association of American medical colleges. FY 1989 COTH survey of hospitals' financial and general operating data.

HOSPITALS PROVIDING DATA FOR FY 1986–FY 1989 (TABLES 1–3)

Hospital	City, State
University of South Alabama Medical Center	Mobile, Alabama
University Medical Center	Tuscon, Arizona
UCLA Medical Center	Los Angeles, California
Los Angeles County-USC Medical Center	Los Angeles, California
University of California, San Diego, Medical Center	San Diego, California
The Medical Center at the University of California, San Francisco	San Francisco, California
Stanford University Hospital	Stanford, California
Harbor-UCLA Medical Center	Torrance, California
John Dempsey Hospital, University of Connecticut Health Center	Farmington, Connecticut
Yale-New Haven Hospital	New Haven, Connecticut
Georgetown University Hospital	Washington, D.C.
Howard University Hospital	Washington, D.C.
Shands Hospital	Gainesville, Florida
Crawford Lone Hospital of Emory University	Atlanta, Georgia
Emory University Hospital	Atlanta, Georgia
Medical College of Georgia Hospital and Clinics	Augusta, Georgia
Rush-Presbyterian-St. Luke's Medical Center	Chicago, Illinois
Foster G. McGaw Hospital	Maywood, Illinois
Indiana University Hospitals	Indianapolis, Indiana
University of Iowa Hospitals and Clinics	Iowa City, Iowa
University of Kansas Hospital	Kansas City, Kansas
University Hospital, University of Kentucky Medical Center	Lexington, Kentucky
Tulane Medical Center Hospital	New Orleans, Louisiana
Beth Israel Hospital	Boston, Massachusetts
Massachusetts General Hospital	Boston, Massachusetts
New England Medical Center, Inc.	Boston, Massachusetts
University of Michigan Hospitals	Ann Arbor, Michigan
University Hospital, University of Mississippi Medical Center	Jackson, Mississippi
University of Missouri Hospital and Clinics	Columbia, Missouri
Mary Hitchcock Memorial Hospital	Hanover, New Hampshire
University of New Mexico Hospital	Albuquerque, New Mexico
University of North Carolina Hospital	Chapel Hill, North Carolina
Duke University Hospital	Durham, North Carolina
North Carolina Baptist Hospitals, Inc.	Winston-Salem, North Carolina
University of Cincinnati Hospital	Cincinatti, Ohio
Oregon Health Sciences University Hospital	Portland, Oregon
Hahnemann University Hospital	Philadelphia, Pennsylvania

HOSPITALS PROVIDING DATA FOR FY 1986–FY 1989 (TABLES 1–3)—Continued

Hospital	City, State
Hospital of the University of Pennsylvania	Philadelphia, Pennsylvania
Thomas Jefferson University Hospital	Philadelphia, Pennsylvania
Regional Medical Center at Memphis	Memphis, Tennessee
University of Utah Hospital	Salt Lake City, Utah
Medical Center Hospital of Vermont	Burlington, Vermont
University of Virginia Hospitals	Charlottesville, Virginia
Medical College of Virginia Hospitals	Richmond, Virginia
University of Washington Medical Center	Seattle, Washington
University of Wisconsin Hospital and Clinics	Madison, Wisconsin

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STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists appreciates the opportunity to comment on recommended budget cuts and Medicare policy initiatives for 1991. The College is a national medical specialty society representing more than 11,000 pathologists who practice medicine in community hospitals, academic medical centers, independent laboratories, and other settings.

College comments focus on Medicare physician services and laboratory policy reimbursement initiatives that are ill-conceived and inequitable. Our comments also address some Administration 1991 budget proposals that will be unnecessarily burdensome and costly to the Federal Government.

1991 RELATIVE VALUE SCALE FOR PATHOLOGY SERVICES

The Omnibus Budget Reconciliation Act (OBRA) of 1989 included two major RVS provisions that affect pathologists. Section 1848 was added to the Social Security Act to establish a relative value scale fee schedule for all physicians' Medicare services effective January 1, 1992. This fee schedule will be implemented or phased-in over a five-year period, and it will be based on an RVS determined by combining physician work (resources) values, practice expense values, and malpractice values into one relative value for each service.

The OBRA 1989 also amended Section 1834 of the Social Security Act to implement a budget neutral RVS-based fee schedule for pathology services effective January 1, 1991, subject to Section 1848 above. The pathology fee schedule is to be based on relative values developed by the Secretary in consultation with organizations representing physicians performing pathology services.

Professor William Hsiao and his colleagues at the Harvard University School of Public Health are conducting a restudy of physician resources involved in pathology services. The restudy, funded by the College, is scheduled to be finished in late 1990. In addition, the College has contracted for design of a study of pathology practice costs in different practice settings.

College of American Pathologists opposes implementation of any RVS fee schedule for pathology services until the Hsiao restudy of pathology services is completed and subjected to rigorous review. The College believes that implementation of the pathology RVS should be postponed pending completion and analysis of Hsiao and other studies currently under way. Implementation on January 1, 1991, of an RVS developed by the Secretary will not allow for careful review of the Hsiao restudy data and of its appropriate use in developing an equitable RVS for pathology services.

The College believes that the Hsiao pathology relative values should undergo a critical review and refinement process following completion of the Hsiao study. The College is committed to development of appropriate relative values for pathology and to review and revision of any proposed RVS to ensure its accuracy.

Implementation in 1991 of a pathology fee schedule, followed by implementation in 1992 of a fee schedule for all physicians including pathology, is not sound Medicare policy in our opinion. The 1991 pathology fee schedule will only cause unnecessary work for the Medicare program and unnecessary disruption for pathologists. There is no benefit to this initiative.

The College urges the Congress to reconsider the 1991 pathology fee schedule provision, and to amend the OBRA 1989 legislation so it will not be implemented.

COMPETITIVE BIDDING FOR CLINICAL LABORATORY SERVICES

Competitive bidding for clinical diagnostic laboratory services has been a topic of debate in Congress for more than five years. In the past, Congress has imposed a moratorium on competitive bidding demonstrations proposed by the Administration because of the unacceptable risk of disrupting beneficiary access to quality laboratory services.

The moratorium has expired because it was inadvertently omitted from budget reconciliation legislation in 1989. The Administration is again seriously considering conducting competitive bidding demonstrations for clinical laboratory services in 1991. This illogical plan appears to stem from the notion that medical diagnostic *services* can be bid, bulk purchased, and provided in much the same manner as manufactured supplies and equipment.

In fact, competitive bidding for clinical diagnostic laboratory services will invite reductions in quality and access to these services for Medicare beneficiaries. Even as a demonstration project, a competitive bidding program for diagnostic services would be administratively burdensome, expensive to implement, and enormously disruptive in the demonstration areas. According to the Federal agency developing the plan, it would be impossible to replicate nationwide.

It is highly questionable whether realistic prices for clinical diagnostic laboratory services would be the product of such a demonstration. More likely, laboratory medicine would be disrupted in the demonstration areas, access and quality would be jeopardized, and no insight into appropriate pricing for laboratory services would be gained.

The Medicare program already controls the pricing of clinical laboratory services through the clinical laboratory fee schedule. Competitive bidding is not necessary.

The College urges the Congress to reinstate a moratorium on competitive bidding for clinical diagnostic laboratory services.

MEDICARE CLINICAL LABORATORY FEE SCHEDULE

In 1984, Medicare payment for outpatient clinical diagnostic laboratory services was reformed, and a fee schedule was implemented. In almost every year since then, the fee schedule has been subjected to reductions, caps, elimination of inflation updates, or other restrictions. Currently, Medicare payment for clinical laboratory services is based on carrier-specific fee schedules and limited by service-specific national caps that are 93 percent of the median of all such fee schedule amounts.

The Administration now proposes further reducing the national caps to 90 percent of the median for most services and to 80 percent of the median for services provided as standardized test packages or profiles. The 1991 inflation update would be eliminated except for fee schedule amounts below the caps. Data on prices charged for services to non-Medicare patients would be used to reduce Medicare fee schedules in subsequent years.

Payment for Medicare clinical diagnostic laboratory services cannot continue to be subjected to such reductions without sacrificing quality and access. The attached statement lists major legislative changes that have restricted payment for Medicare clinical diagnostic laboratory services.

The College urges the Congress to allow a period of stability in Medicare payment for clinical laboratory services by rejecting the Administration's proposals for 1991. The Medicare clinical laboratory fee schedules should receive the full scheduled inflation update for 1991 and should not be subjected to reductions in the national caps.

Data on non-Medicare charges for these services is unsuitable for use in setting fee schedule amounts for services to beneficiaries of the Medicare program which imposes extensive billing and payment restrictions on providers. Non-Medicare payers often allow batch billing (which reduces billing costs) and do not require the extensive reporting that the Medicare program demands.

MEDICARE PAYMENT FOR GRADUATE MEDICAL EDUCATION

The Federal Government supports graduate medical education (GME) of the nation's physicians through payment to hospitals for their direct and indirect costs in this regard. Since 1983, payment for indirect medical education costs has been included as an element of the hospital prospective payment system (PPS) with payments to qualifying teaching hospitals increased 7.7 percent for each 0.1 increase in the hospital's ratio of interns and residents to beds. This adjustment is to compensate teaching hospitals for higher costs in patient care associated with the training of physicians that are not accounted for in the PPS rates.

Direct medical education costs (salaries and other overhead costs) are reimbursed separately but also prospectively, based on the hospital 1984 cost per resident ad-

justed for subsequent increases in the level of consumer prices. Although these payments represent only about 2 percent of Medicare inpatient payments, one-sixth of hospitals receive this reimbursement and it is estimated by the Congressional Budget Office to cover one-third of hospitals' total graduate medical education costs.

The Administration proposes to reduce payment for both direct and indirect graduate medical education. The reduction in the indirect GME payment would be a significant reduction in the adjustment factor from 7.7 percent to 4.05 percent. The direct GME reduction would be achieved through establishment of a per resident payment derived from 1987 resident salary data. The result would be a reduction of $205 million in payment in direct GME costs in 1991.

Such reductions in payment to hospitals that conduct essential training programs for physicians will cause erosion of the nation's medical education system and undeserved hardship on teaching hospitals, which also care for a disproportionate share of indigent patients. Hospital closures or reduction of residency positions is likely to result. Access to needed health care services in some communities will be reduced.

Pathology residency programs would be particularly affected by the proposed reductions. The average age of pathologists is now 52 years, with the average age of retirement 62 years. A large proportion of pathologists are expected to retire by the end of this decade, and there is no current surplus of pathologists to fill the void left by the retiring pathologists. In fact, there is a serious shortage of pathology residents at this time. A shortage of pathologists is predicted for the mid-1990s. With continual decreases in GME payment it is increasingly difficult for hospitals to maintain residency programs that would train pathologists for the future.

The College urges the Congress to continue support of needed physician training programs by opposing the severe cuts for these services proposed by the Administration.

VOLUNTARY HOSPITAL PHYSICIAN PARTICIPATION

The Administration proposes to allow hospital administrators to sign an agreement with the Medicare program guaranteeing that assignment would be accepted for emergency services, radiology, anesthesia, pathology services, and consultations by all physicians. A hospital would be able to advertise its status as a Medicare "participating medical staff hospital" in an attempt to compete with other nonparticipating hospitals.

The College opposes expansion of Medicare assignment authority for physician services to non-physicians—the Voluntary Hospital Physician Participation Proposal.

The Medicare program is about to implement a major change in the manner in which physician services are reimbursed—the Medicare Fee Schedule (MFS) based on resources. Stringent limitations on balance billing for unassigned services will accompany the MFS.

To impose upon this new payment system a program in which hospitals have vague competitive or economic incentives to pressure the entire medical staff to accept assignment is an invitation for medical staff/hospital disruption and misunderstanding. If medical staffs wish to voluntarily accept assignment, they may do so now and join the hospital in such an advertising campaign.

The Voluntary Hospital Physician Participation program should be rejected as divisive to physicians and hospitals and unnecessary to protect Medicare beneficiaries.

USER FEES FOR HEALTH FACILITY SURVEY AND CERTIFICATION

The Administration proposes to tax health care facilities, in the form of a "user fee," for performing survey and certification procedures required to ensure that the facilities adhere to Medicare conditions of participation. The fees would be used to fund expected increases in Federal survey and certification activities required by the Clinical Laboratory Improvement Amendments of 1988 and other laws, including hiring of an additional 170 full-time equivalents to perform these services.

It is not necessary to tax health care facilities for laboratory inspection and certification provided by the private sector. The private sector, in cooperation with the Department of Health and Human Services, has historically provided these services without imposing Federal fees and has the capability to continue to do so.

Laboratory medicine has a long history of regulation, inspection, and certification by the Medicare program. Inspection and accreditation of health care facilities is conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The College of American Pathologists Laboratory Accreditation Program (CAP-LAP) inspects and accredits more than 4,000 hospital and independent laboratories. The JCAHO accepts CAP-LAP accreditation, and JCAHO accreditation is accepted by the Medicare program as meeting its requirements. These private sector

programs provide a valuable response to federally mandated standards and are viable alternatives to Federal user fees for the same purpose.

Likewise, the Commission on Office Laboratory Assessment (COLA), a collaborative effort of the College of American Pathologists, the American Academy of Family Physicians, the American Society of Internal Medicine, and the American Medical Association, was created to provide accreditation for physician office laboratories.

The College believes that these private sector approaches represent a desirable and appropriate alternative to costly government survey and certification of laboratories. It is not necessary to impose Federal user fees on laboratories to finance laboratory accreditation activities. The private sector has demonstrated the ability and willingness to undertake this active at no cost to the Federal Government. The programs should be encouraged and their involvement enhanced through granting of Medicare "deemed status" applications.

The user fee proposal should be structured to ensure that survey and certification activities provided by the private sector are not duplicated and health care facilities are not doubly charged.

CONCLUSION

On January 1, 1991, the Department of Health and Human Services is required to implement a pathology relative value scale and fee schedule that is separate from the fee schedule to be implemented for all of medicine in 1992. The College of American Pathologists urges the Congress to reconsider this requirement and amend OBRA 1989 so the 1991 fee schedule will not be implemented. Pathology would then begin implementation of the 1992 Medicare fee schedule with all other physicians.

The Administration's 1991 budget document includes several initiatives that, if implemented, will threaten the ability of the nation's health care facilities to provide quality laboratory medicine. Laboratory medicine cannot continue to be the target of budget reductions, restrictions, caps, user fees, and disruptive ill-conceived "competition" initiatives, year after year, without jeopardizing these services.

The College encourages the Congress to carefully consider the budget deficit initiatives aimed at laboratory medicine that are proposed by the Administration and to reject them.

As always, the College is ready to work with the Congress to ensure high-quality laboratory medicine.

The College appreciates the opportunity to comment on the Administration's 1991 budget proposals.

Statement of Jim Mattox, Texas Attorney General

INTRODUCTION

In Texas, the Title IV-D child support enforcement program has been administered by the Office of the Attorney General since 1983. Prior to 1983, the Texas Department of Human Services operated the program. Because child support was overlooked and given a relatively low priority in the large human services agency, I offered to absorb the program into the Attorney General's Office.

I have made child support enforcement a top priority in my administration and the effort has paid off. Since the program moved to the Attorney General's Office, tremendous improvements have been made. Collections and efficiency have increased dramatically while the caseload has more than doubled. At the end of State Fiscal Year (SFY) 1983, the average monthly number of cases was 177,135; at the end of SFY 1989, the caseload totalled 436,223. Since I accepted responsibility for administering the program, collections have increased 639%, going from $18 million in 1983, to over $133 million in 1989. The National Child Support Enforcement Association (NCSEA) recognized this progress by honoring me with the first ever "Most Improved Program" award in August of 1989.

These improvements took place despite the fact that state funding for the Texas program increased an average of only 20% a year from 1983 to 1988. However, recognizing the remarkable progress the program has achieved, the 71st Texas Legislature substantially increased its funding and strengthened it by increasing the Office of the Attorney General's authority in child support cases.

Even though the program is forging ahead at great speed and with tremendous results, much more needs to be done. Changes to Federal regulations and Federal funding formulas for the IV-D program should be considered if states are to seriously address the growing national child support caseload. Because Title IV-D is a com-

plicated program, any proposals concerning child support enforcement should be given careful consideration to ensure that they will help and not hurt the IV-D program. President Bush has included in his budget proposals for FY 1991, several recommendations which may adversely affect the Texas IV-D program and others.

Among the proposals are the following:

(1) require states to establish sliding-fee schedules to recover a portion of the cost of funding child support enforcement from both absent and custodial parents;

(2) cap the amount of Federal matching funds available to states for administering Title IV-D child support enforcement programs at 100% of their support collections on behalf of AFDC families, with gradual reductions to 66% by FY 1999;

(3) include food stamp recipients among those for whom states are required to provide Title IV-D child support establishment and enforcement services.

The first proposal would impose a sliding fee for IV-D services with the fee being assessed against both the absent and custodial parents. It would be based upon their respective abilities to pay and would not be due until current support obligations are satisfied. Such a change represents a significant departure from current law, which permits states to charge up to $25.00 as an application fee for non-AFDC clients. AFDC clients are not charged for child support services.

In Texas, the application fee is $20.00. Income from this application fee amounts to only .34% of the budget for the Texas Attorney General's Child Support Enforcement Division. A number of states do not charge any application fee, finding the administrative costs associated with collecting and processing to exceed the income from the fee. In Texas and other states having large numbers of non-AFDC clients (56% of Texas' Title IV-D cases are non-AFDC), there would likely be opposition from these clients for having to pay a fee. These clients believe that, if a charge for enforcement of court ordered child support is to be assessed, it should be assessed against the delinquent obligor who has violated the court's order to pay child support. Depending upon the amount of fees that could be assessed, it may not be cost effective for the IV-D program to seek to obtain the necessary income information from which to make a determination, and to administer a sliding fee, income-tested cost recovery program. Further details of the specific proposal would be necessary to fully assess its total costs and benefits. An alternative cost recovery idea that Congress could consider would be to increase the late fees or penalties a state may charge a delinquent obligor. Current Federal law (42 U.S.C. 654) provides that a state may impose a late fee on all overdue support in a amount of not less than 3% or more than 8% of the overdue support. Raising this penalty to 20-30%, and permitting the state IV-D agency to retain this penalty as program income (against which there would be no corresponding Federal offset), would create a significant new revenue source for state programs in addition to providing a specific disincentive against delinquency by child support obligors.

The second and third proposals by the Bush Administration have a direct relationship to the current method by which state IV-D programs receive Federal matching dollars and incentives. The current system of Federal funding for the Title IV-D program involves two different approaches. One involves Federal matching dollars, known as Federal financial participation (FFP), for which each appropriated "state" dollar is matched by two Federal dollars. In addition, a state may receive Federal "incentives" based upon a "cost-effectiveness" formula of the Title IV-D agency. Under the second Bush Administration proposal, Federal matching dollars available to a state would be "capped" at an amount equal to the state's recovery of AFDC through child support enforcement efforts of the Title IV-D program.

The problem with the current incentive formula (which is exacerbated by the Bush proposal to cap available FFP at the level of AFDC recovered) is that it has little relationship to the efficiency and effectiveness of the Title IV-D agency. For example, consider a state, such as Texas, which has a low AFDC grant level. The same effort by the Texas IV-D program to recover $170 in AFDC in Texas (the average AFDC monthly grant) would result in as much as $651 in Alaska, a high AFDC grant state. In addition, Texas has a very large number of non-AFDC clients. They are organized and very aware of their rights under Federal law to the "equal" provision of IV-D child support enforcement services. As a result, the Texas IV-D program must respond to their demands for services. In fact, Texas is being sued by non-AFDC clients for providing what they believe to be faster and more vigorous services to AFDC clients, despite the fact that 56% of the Texas caseload is non-AFDC, and 70% of the collections are non-AFDC. The current cost-effectiveness formula also favors states with "central registries" that effectively make most of those states' child support payments "IV-D payments," whether or not enforcement

action is needed. Thus, these states have a very high non-AFDC cost- effectiveness ratio and recover higher incentives. Whether a state has an effective central registry has a great deal more to do with that state's intergovernmental structure and history than with the ability or performance of the IV-D program.

Also, with the current incentive structure, a state IV-D program that has, historically, been significantly underfunded (and which has had correspondingly below average performance), faces a major problem if their legislature begins to significantly increase its state appropriation. For example, the Texas Legislature almost doubled the budget for the Texas IV-D program for FY 90-91 to help it get closer to funding levels of other large states' IV-D programs. With the addition of hundreds of new staff and dozens of new offices, cost-effectiveness will decline in Texas for the first time during the six years the Office of the Attorney General has administered the program. Thus, due to the current incentive formula, the percentage of our Federal incentives will not increase. Again, this has nothing to do with the performance or effectiveness of the Texas IV-D program, rather it is simply an undesirable result of an outdated Federal incentive formula.

In addition to considering a funding "cap" for Title IV-D programs as proposed in the Bush Administration's budget, Congress should consider a totally new formula for allocating which states receive their fair share of this decreasing Federal pie. As pointed out earlier, the Texas IV-D program has historically been at a disadvantage in receiving its fair share of Federal funds, due, in part, to circumstances unrelated to its performance. Now, it seems that Texas' IV-D program, and those of other states similarly disadvantaged by the Federal incentive formula, should be given an opportunity to earn incentives commensurate with their program's improvement and their performance in a variety of important targeted child support establishment, enforcement and collections activities.

Congress should also consider rewarding states where their legislatures have wisely chosen to reinvest all earned revenue from their Title IV-D programs back into child support enforcement efforts. Congress' current concern about the states "profiting" at the expense of the Federal government (where states fail to appropriate to the IV-D program all incentives earned by the IV-D program) is understandable. However, beginning last year, the Texas Legislature appropriated to the IV-D program all Federal incentives which it earned. In FY 89, this amounted to $5,052,000. In addition, the Legislature appropriated to the IV-D program all of the state share of AFDC recovered. In FY 89, this amounted to $11,570,709. Both of these amounts became the state appropriation, against which $31,481,341 in Federal financial participation (FFP) was provided by the Federal government. Such an arrangement would appear to address the concerns expressed by the Bush Administration and Congress that the states are profiting through use of Federal dollars intended for child support enforcement efforts to fund other non-child support enforcement activities. Perhaps Congress could encourage states to "reinvest" in the IV-D program by, among other things, imposing a cap on FFP to any state that fails to reinvest in the IV-D program both its earned Federal incentives and its state share of AFDC recovered. Those states that choose to continue using these funds for non-IV-D activities would have their FFP capped, perhaps along the lines proposed by the Bush Administration, and their matching FFP rate lowered.

Finally, the third Bush proposal relating to the Title IV-D program would effectively require participants in the food stamp program, who are not also AFDC recipients, to become clients of the Title IV-D program. In Texas, this could result in thousands of additional non-AFDC clients. Already, due to the current IV-D incentive limitation, Texas receives no incentives for non-AFDC collections made on behalf of clients for whom $61,374,230 was collected in 1989. This third proposal by the Bush Administration would add even more work to the Texas IV-D program, yet Texas would not receive one additional cent in Federal incentives for working these new non-AFDC cases. This would be the same result for approximately forty other states' IV-D programs, where no additional non-AFDC incentives can be earned by the state because of current Federal law prohibiting non-AFDC incentives beyond 115% of the amount of AFDC incentives earned by the state. Instead, Congress should provide that any recovery resulting from child support enforcement by state IV-D programs involving recipients of food stamps, medicaid, foster care, and other governmental programs, be treated as AFDC recovery. This would allow state IV-D programs to obtain additional program incentives for working these cases. If Congress were to provide inducements to states to reinvest the state share of recovery for any of these programs that has a state share of recovery (as Texas does for AFDC recovery) into the Title IV-D program, it would add significant new revenues to assist state child support enforcement agencies in their efforts. Additionally, for those programs where there is no state share of recovery, such as food stamps, Con-

gress could provide state IV-D programs with a certain amount of the Federal share of AFDC recovered to count as earned revenue and which the state would then be encouraged to reinvest in their IV-D program.

In conclusion, Congress needs to give careful consideration to each of the proposals being offered by the Bush Administration for changes to the Title IV-D program before taking action. Increased penalties and late payment fees should be considered as an option before requiring state IV-D agencies to administer an income determination and sliding fee application process. If Congress is going to require overburdened state IV-D programs to take on new, additional non-AFDC caseloads, such as food stamp recipients, then they must consider some additional method of allocating Federal incentives to help those states with disproportionately high non-AFDC caseloads. The current system of incentives must be revised so that incentives are paid to states based upon actual, measurable performance accomplishment rather than the current method, ostensibly based upon "cost-effectiveness." Finally, states should be encouraged to "reinvest" earned revenue from their IV-D program back into that program and states that do so should be rewarded with higher amounts of Federal matching dollars.

Statement of the National Alliance of Physicians and Surgeons

Chairman Bentsen, Senator Packwood, Honorable Members of the Committee: My name is Robert E. Moffit and I serve as a consultant and Executive Director to the newly formed National Alliance of Physicians and Surgeons. Before re-entering private life last year, it was my high privilege to serve as Principal Deputy Assistant Secretary for Legislation at the Department of Health and Human Services under Secretary Otis R. Bowen.

Before I elaborate upon the substance of my remarks, I would first like to extend my deep appreciation to the Chairman and the fine professional staff of the Committee for the opportunity to submit this formal statement. In my recent capacity as an officer of the Executive Branch, I came to know and appreciate the professionalism, the dedication, the long hours and hard work, and above all, the integrity of both the majority and minority staff. That experience was both professionally exhilarating and personally rewarding.

The National Alliance of Physicians and Surgeons is literally weeks old, not much older indeed than the Administration's Budget Proposals for FY 1991. Founded in Fort Lauderdale, Florida, by Dr. Harvey Kugel, a cardiologist, and Dr. Richard Neubauer, a specialist in internal medicine, the National Alliance of Physicians and Surgeons was formed for the purpose of maintaining the integrity and independence of private medical practice, regardless of medical specialty or professional interest.

From that broad perspective, we *oppose* adoption of the Administration's Fiscal Year 1991 Budget Proposals for the Physician Reimbursement in Medicare Part B and the implementation of the Resource-Based Relative Value Scale (RBRVS) as the new schedule of physician reimbursement. We favor a repeal, or at least a delay, of the new fee schedule. The Administration's Fiscal Year 1991 Budget Proposals cannot be understood apart from the implementation of the Resource Based Relative Value Scale for Medicare payment. Indeed, the Administration's Budget package explicitly builds upon this change in the fee system enacted last November.

FISCAL YEAR 91 REDUCTIONS

The Administration has proposed nine separate items impacting physicians in its Medicare Part B budget package. The most significant items, such as another round of cuts in "overpriced" procedures, cuts in payments for practices in "overpriced" areas, a second round of cuts for radiologists and anesthesiologists, and a flat reduction in the global surgical fee aggravate the impact of budget cuts made in the Federal budget last year. In other words, in an effort to contain costs, the Administration budget is concentrating again on diagnostic and procedural specialists for the bulk of the projected $1 billion in savings to be realized from physicians' services. The impact these proposals goes beyond material consequences for doctors who take Medicare patients. After all, the Congress and the Administration have just enacted far reaching reforms for physicians' reimbursement, the full implications of which are neither clearly understood nor fully appreciated within the medical profession. The chief target of those reforms is largely the same class of physicians and surgeons disproportionately impacted by these budget proposals. These physicians should be given some breathing room and time to recover from last year's changes. Enough is indeed enough. We hope that Congress would agree.

In this connection, the Committee is aware of recent items in the general media and the professional journals concerning the conditions of modern medical practice. Demoralization within the medical profession is becoming a genuine problem. Many physicians and surgeons sense they are losing control over their own profession, and fear for the future of private practice. Without belaboring the issue, we would ask the Committee to take this emerging problem into consideration during its deliberations on the Budget Reconciliation legislation this year.

THE IMPLEMENTATION OF THE RBRVS

As we have already indicated, we oppose the adoption and the implementation of the Resource Based-Relative Value Scale. On a conceptual level, we oppose it as incompatible with the future independence of private practice and market principles. On an operational level, we would respectfully call the Committee's attention to the fact that the process of implementation has raised for more troubling questions than satisfactory answers from the Federal authorities charged with making it work.

In the context of the Administration's Budget Policy, we would also call the Committee's attention to the eloquent statement of OMB Director Richard Darman. In his introduction to the FY 1991 Budget, Director Darman celebrates the collapse of "state centered, command and control systems" of economic regulation. The Director further warns us that, "It would be a highly unfortunate irony if—just as the world were affirming more market oriented and investment-oriented principles—the United States were to do anything other than strengthen its commitment to these very principles."

Put simply, the implementation of the RBRVS is flatly inconsistent with the Administration's own stated budget policy. If the premise of an argument is true, then the conclusion must logically be true. The fundamental premise of the RB-RVS is that market forces do not work in health care delivery, and therefore a non-market calculation of the "value" of a physician's labor, plus the costs of his practice is preferable. We are aware that there is a considerable body of literature that supports the idea that health care delivery is not amenable to market forces or market analysis, but surely the scientific literature on the subject is not unanimous and many reputable economists of national stature would doubtless argue otherwise. As it stands now, the Administration and Congress are preparing to impose a theory of job "value" and wage-setting on a class of private citizens they have thus far refused to impose on any other class of American citizens, including members of the Federal civil service. The employment of a sophisticated social science model for the determination of wages and prices surely has implications beyond one class of professionals. What we have here is a major question that goes to the very heart of our public policy. In any case, the very gravity of the basic premise—the utter unworkability of market forces—underlying the entire edifice of the RBRVS should encourage a general Congressional reconsideration.

Another focal point of Congressional review should be the admitted limitations of the RVS methodology itself. We do not quarrel with the fact that the massive study of Professor William Hsiao and his team at Harvard University is an impressive social science research effort. As with all good scholars, Professor Hsiao and his colleagues honestly affirm the limitations as well as the strengths of their research. But public policy is not a research project; it is the exercise of the authority of government on behalf of its citizens. In developing the RBRVS, its architects acknowledge that no provision is made for reimbursing a physician or a surgeon in terms of the "quality" of the medical service or the "benefit" derived from it. In the September 1988 edition of the *New England Journal of Medicine,* Professor Hsiao et al. argue that with more time and more research, they may be able to refine their methodological techniques and develop a "quality index," for example, for physicians' services. (See William C Hsiao et. al. "Special Report," *New England Journal of Medicine,* Vol. 319, No. 13, p. 888). But in the meantime, no such index exists, either for "quality" or "benefit;" and it is not at all clear how HCFA is supposed to provide input for either in the implementation and application of the RBRVS. Quality assurance is not merely a matter of administrative enforcement, but should be integral to any new physician payment system. Whatever weaknesses one may attribute to market determinations, both the quality and the benefit of a service are two elements to which a market responds with the most admirable flexibility. Before the new fee system is implemented, HCFA should be required to address this aspect of the fee system. In the absence of indices of quality or benefit within the RBRVS formula, we are entitled to know how HCFA is to supply these elemental deficiencies.

Thirdly, we are troubled by both the substance and the tone of HCFA's own official statements on the impact of the new fee system on access to care in the Medicare system. After all, this is the agency charged with administering the RBRVS. In its official 1989 Report to the Congress on Medicare Physician Payment Reform, HCFA argued for a "cautious approach" toward implementation of a national fee schedule, noting that "the effects of resource-based fee schedule on access to care cannot be predicted with confidence." In arguing for a cautious approach and a long lead time for implementation, HCFA is clearly trying to avoid any disruptions in the Medicare delivery system. Granting the smoothest transition process, however, the creation of disincentives to accept Medicare assignment for whole classes of physicians cannot be without negative consequences. Indeed, in its own report, HCFA observes, "Nonetheless, because the changes in payment that would result under the fee schedule are far more extensive than previous changes, there is simply no reliable basis for predicting the response of physicians either in terms of willingness to treat Medicare patients or willingness to accept assignment. This uncertainty argues for a cautious approach toward fee schedule implementation." We would argue—to the contrary—that this very uncertainty calls for a halt to implementation until HCFA can provide the Congress and the public with a clearer idea of the consequences of the new system for access to quality health care. For a system that provides for the medical needs of 32 million elderly Americans, a more confident projection of access levels should be required of HCFA.

Finally, we would call the Committee's attention to the magnitude of the managerial task facing HCFA in the administration of the RBRVS system. Again, in its own 1989 Report to the Congress, HCFA has called attention to the fact that the administration of the RBRVS will be far more demanding than the administration of the PPS system for hospitals: "Implementation of a national fee schedule is an enormously complex undertaking—far more complex than implementation of the prospective payment system of hospitals. The complexity of the task is evident in the fact that there are 7,000 physician payment codes (475 DRGs), 500,000 physicians (7,000 hospitals), and about 400 million claims (11 million inpatient hospital claims)."

Clearly, any ambitious program of central planning, on such a scale as contemplated here, will require a mammoth amount of detailed, rigorously developed and applied information. In order to achieve an "objective" standard of reimbursement under the RBRVS, HCFA will have to develop relative value units for each of the thousands of medical procedures, incorporate geographic and malpractice cost factors, and develop—on the basis of the RBRVS study—reimbursement levels for codes not specifically included in the Harvard Study. We would also note, in passing, that the very purpose of the RBRVS is to ensure a scientifically "objective" reimbursement program to ensure a "level playing field" among different medical specialties; a purpose logically contradicted by the legal authority of the Secretary of HHS to make his subjective modifications.

The credibility of the RBRVS will be dependent not only on its in management, but also on the quality and quantity of the data. In this respect, the Congress has already heard expert testimony expressing concern over the completeness and the timely delivery of such data. While we do not favor the employment of the RBRVS as a fee system in the first place, we would hope that, if the Congress insists on adhering to a January 1, 1992 implementation date, it will scrutinize the quantity and the quality of the data before actual implementation.

In conclusion, Mr. Chairman, the National Alliance of Physicians and Surgeons opposes the adoption of the Administration's Budget proposals for Medicare reimbursement as well as the implementation of the Resource Based Relative Value Scale. On the RBRVS, we believe that the fundamental approach and the implementation of the new system raises more questions than it resolves. And while we sincerely appreciate the need for savings in the Medicare program, we would prefer an across-the-board-freeze in physician reimbursement rather than further cuts, especially for classes of physicians who have already been on the receiving end of significant reductions as a result of last year's budget changes.

Thank you again, Mr. Chairman, for the opportunity to submit our statement. We stand ready to work with the Committee and its fine staff on these and other matters of interest to you.

STATEMENT OF THE NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS

I. INTRODUCTION

The National Association of Portable X-Ray Providers (NAPXP) submits this statement on the Bush Administration's budget proposals for Fiscal Year (FY) 1991. The Association is a ten-year old organization representing suppliers of portable x-rays throughout the United States. The NAPXP is vitally concerned about Medicare budget actions because over 90 percent of portable x-ray services are reimbursed by Medicare.

II. BACKGROUND ON THE PORTABLE X-RAY SERVICE AND MEDICARE REIMBURSEMENT

A. The Nature of the Portable X-Ray Service

Portable x-ray suppliers are companies that bring x-rays to the bedsides of elderly homebound or nursing home patients. Typically, they are small, literally "Mom-and-Pop" firms founded by former x-ray technologists who remain closely involved in the day-to-day business.

The portable x-ray service is provided entirely by specially qualified, non-physician technologists. The only alternative is transporting the patient in an ambulance to a hospital, which entails potentially injurious physical movement and mental trauma. The portable x-ray service generally costs one-third to one-fourth as much as the ambulance alternative, and provides a faster turnaround of films to the attending physician, thus speeding diagnosis and treatment of injuries. Portable x-rays are functionally different from physicians' office x-rays and much costlier to provide because of the special difficulties created by, and training required for, a geriatric, infirm clientele and the need to transport the x-ray equipment and then assemble, dismantle, and reassemble it for each patient who is x-rayed.

B. History of Medicare Reimbursement of Portable X-Ray Services

Portable x-ray services have been covered by Medicare since early in the history of the Medicare program, and have been recognized by statute as non-physicians' services. *See* 42 U.S.C. §1395x(s)(3). Similarly, the Health Care Financing Administration (HCFA) devised a unique payment instruction for portable x-ray services that is embodied in a separate section (5244) of the Medicare Carriers Manual.

Notwithstanding this recognition of the portable x-ray service by Medicare program authorities as a unique, non-physician's service, the portable service has been ignored or misunderstood by the local Medicare carriers because of the relatively minuscule size of the business: portable x-rays represent less than 2 percent of all Medicare radiology procedures. Consequently, Medicare carriers in many parts of the country have historically treated portable x-ray services incorrectly as physicians' services, despite many efforts by portable x-ray suppliers to explain that physicians are not involved in providing the service and that it does not resemble the type of x-ray normally provided to ambulatory patients in physicians' offices.

This historical misunderstanding by carriers has been reflected in two ways. First, many carriers erroneously subjected portable x-ray suppliers to the Medicare physicians' fee freeze of 1984–1986. Second, throughout the 1980s carriers historically reimbursed portable x-ray suppliers, contrary to the direction in Section 5244 of the Carriers Manual, by "commingling" portable x-ray charge data with physicians' office x-ray charge data in determining prevailing charges. Because portable x-rays are much costlier to provide than physicians' office x-rays, portable x-ray charges are necessarily higher than those for physicians' office x-rays. Consequently, the commingling of portable x-ray charge data for 2 percent of procedures with physicians' office charge data for 98 percent of procedures created prevailing charges for portable x-ray services that were far lower than they would have been if only portable x-ray data had been used. HCFA itself stated in 1985 that the carrier "commingling" practice was improper, but carriers continued to use it. Because of these errors, Medicare portable x-ray payments throughout the 1980s were suppressed below even *correctly* calculated Medicare payment levels—while staff salaries and other costs of doing business continued to rise.

Before 1988, the general principle for reimbursement of portable x-ray services was the "reasonable charge" method that set Medicare payment at the lowest of the actual, customary, and prevailing charges. In the Omnibus Budget Reconciliation Act of 1987 (OBRA'87), Congress mandated a new fee schedule reimbursement methodology for physicians and "suppliers" of radiology services. 42 U.S.C. §1395m(b). The new law directed HCFA to develop a relative-value-based fee schedule for all such radiology services.

It was at this point that the NAPXP first approached HCFA to discuss the portable x-ray business and explain the considerable differences between portable x-ray services for infirm, elderly patients and physicians' office x-rays for ambulatory patients. HCFA recognized these functional differences and the fact that the portable x-ray service is not in any way a physician's service. *Consequently, HCFA established a separate fee schedule solely for reimbursement of portable x-ray services.* Additionally, the agency made a commitment to resolve the historical "commingling" problem, albeit after the initial implementation of the portable x-ray fee schedule. In fact, HCFA officials are now developing a methodology for carriers to use in correcting the commingling problem. (However, the problem is complex, and the implementation of HCFA's corrective methodology by carriers may be a difficult and time-consuming process.)

In 1989, the Administration proposed and Congress enacted a 4 percent payment cut for radiology services. During the Congressional consideration of these payment cuts, the NAPXP argued that they should not apply to portable x-ray services. The NAPXP pointed out that portable x-ray services are not physicians' services, and that portable x-rays cannot be considered "overpriced" because of the historical suppression of portable x-ray reimbursement. In addition, the NAPXP argued that portable x-rays are by far the most efficient and effective means of providing x-rays to nursing home and homebound patients. The only alternative is that of taking the patient in an ambulance to a hospital, which is far costlier and may not be available at all in some rural areas. Where the ambulance option is substituted, elderly patients may be at risk for physical and emotional trauma, and Medicare costs would certainly increase. Thus, the NAPXP showed that it is in the interests of the Medicare program, with regard to both cost and quality of service, to encourage the continuation and expansion of the portable x-ray service through adequate Medicare payment rates. Ultimately, Congress accepted these arguments and treated portable x-rays as non-physicians' services that were excluded from the 4 percent cut. See Section 6105 of OBRA'89.

III. ADMINISTRATION BUDGET PROPOSALS FOR FISCAL YEAR 1991

This year, the Administration has again proposed to cut Medicare payments for radiology services. The Department of Health and Human Services (HHS) budget proposal for FY'91 states:

> In OBRA'89, the Congress reduced payments for radiology and anesthesia services: radiology fees were reduced by 4 percent and changes were mandated in payment for anesthesia time. For 1991, we are recommending reductions in Medicare payments for radiology and anesthesia services in order to further reduce their overvaluation.
>
> We are proposing that radiology and anesthesia fees be reduced by the amount that current fees exceed an estimated resource based fee schedule. The fee schedule would be estimated by reducing the 1990 national average conversion factor by 10 percent (less than the full amount we estimate these services are overvalued). The maximum reduction for any locality in 1991 would be 25 percent.

HHS Press Release on Budget Proposals for the Medicare program (January 29, 1990) at 49–50. This language describes "radiology" services as those that were cut last year by 4 percent. Portable x-rays were not covered by that cut. Thus, it is appropriate to conclude that the "radiology" services that the Administration proposes to cut this year are limited to the physicians' radiology services that were cut in OBRA'89.

The Administration has also proposed to cap the "technical components of diagnostic and radiology tests" by applying a median-based national limitation similar to that imposed on clinical laboratory reimbursement since 1986. Again, the Administration proposal discusses "radiology services." We believe it is appropriate to interpret this proposal as applying only to physicians' radiology services, not portable x-rays.

In fact, our conclusion that these HHS budget proposals for "radiology" services do not apply to portable x-rays has been confirmed by officials of HCFA, who have stated that the proposal is not meant to apply to the non-physician portable x-ray service.

IV. CONGRESS SHOULD LEAVE PORTABLE X-RAY PAYMENTS UNCHANGED THIS YEAR

In view of Congress' decision in OBRA'89 to treat "radiology" services as not including portable x-ray services for purposes of cuts, we believe portable x-ray serv-

ices should again be excluded from the proposals for radiology payment cuts this year. To do otherwise would run counter to Congress' recognition last year that the historical suppression of portable x-ray reimbursement under Medicare, and Medicare's policy interests in encouraging this service, contradict and militate against the treatment of portable x-ray services as "overpriced" procedures that should be subjected to cuts.

The appropriateness of a "hands-off" policy for portable x-ray services this year is underscored by the pendency of HCFA's project to correct the historical effect of "commingling." This project should be finished, and its impact on portable x-ray reimbursement assessed, before any further cuts are made. Further, another important project should be completed before Congress makes any further decisions about payment levels for portable x-rays. This project is a study, mandated by Congress in OBRA'89, of the costs of furnishing portable x-ray services and the appropriateness of the separate portable x-ray fee schedule. See Section 6134 of OBRA'89. The study is due in December 1990. Its results will bear directly on the question of whether any changes should be made in portable x-ray reimbursement. Congress should have the benefit of the study before any decisions about such cuts are made.

Finally, if any proposals are made to include portable x-rays in radiology payment cuts, it is imperative to take a close look at the numbers. Because portable x-rays constitute only 2 percent of Medicare radiology services, reimbursement cuts for this service would provide negligible deficit reduction benefits. But because Medicare pays for over 90 percent of all portable x-rays, any Medicare payment cuts can drastically affect the health of the portable x-ray business. The industry is already vulnerable because so many of its members are small shops, payments have lagged far behind costs throughout the 1980s, and there is a serious nationwide shortage of portable x-ray technologists. Reimbursement cuts, on top of these existing pressures, could drive many of the smaller companies out of business. Congress should not risk compromising the availability of this highly cost-effective Medicare service by subjecting it to payment cuts.

V. CONCLUSION

HCFA officials have stated that the Administration's FY'91 Medicare budget cutting proposals for radiology do not apply to portable x-rays—in accordance with Congress' exclusion of portable x-rays from radiology cuts in OBRA'89. Congress decision last year rested on important legal, economic and policy considerations that have not changed. Congress should take the same action this year and exclude portable x-rays from any radiology payment cuts for FY 1991.

STATEMENT OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. Chairman, Members of the Committee, I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH consists of approximately 90 public and non-profit hospitals that serve as major referral centers, teaching hospitals, and hospitals of last resort—"safety-net hospitals"—for the poor in most of our nation's largest metropolitan areas.

I am pleased to have this opportunity to express our opposition to the $5.5 billion in cuts to the Medicare program proposed in President Bush's fiscal year 1991 budget, and to testify on the current impact of the Medicare prospective payment system (PPS), and other recent health system changes, on the situation of our nation's important "safety' net" hospitals. I would also like to take this opportunity to address the tremendous volume of low income patients of low income patients served by our nation's safety net hospitals—including many millions who lack even Medicaid coverage—and to recommend further, Federal reforms in this area as well.

Of the proposed $5.5 billion in Medicare budget reduction measures proposed in the budget, $4.1 billion, or seventy-five percent, would come directly from hospitals. Much of the proposed reduction in Part B outlays will also affect hospitals. Hospitals will thus bear the burden of over ten percent of the entire spending reduction proposed to meet the Gramm-Rudman targets.

This is occurring during a period of financial crisis for hospitals, and especially for those hospitals serving the poor. Sixty five percent of all hospitals will suffer losses treating Medicare beneficiaries in FY 1990. Two-thirds of those hospitals will incur deficits greater than ten percent, and the average loss will be 8.4 percent. The member hospitals of NAPH, however, collect third party patient care revenues equal to only about 70 percent of the total costs of treating the patients they serve. Without direct state and local subsidies, the deficits in these hospitals would average 30 percent. Even after direct subsidies are taken into account, most safety net

hospitals will still experience operating deficits averaging nearly 7 percent, or $9 million, on average operating expenses of $143,000,000. Indeed Mr. Chairman, if the hospitals I represent were patients, I am afraid that the news this morning would not be encouraging. The condition of many of these facilities has deteriorated to critical. Some have recently been placed in intensive care or resuscitated only with the financial or administrative equivalent of medical miracles. In Chicago, New York, Los Angeles, Kansas City, New Orleans, and many other cities, the story is the same:

- Trauma centers and emergency rooms are overcrowded to the breaking point.
- Occupancy rates continue to rise, topping 100 percent in some cities, and critically ill patients wait up to 36 hours for an inpatient bed.
- Drug abuse, gang violence, AIDS, the homeless, refugees and other problems new in the 1980's are growing at an alarming rate in some cities—greatly compromising and in some cases even crowding out their ability to serve less seriously ill indigent patients.
- And even as you debate potential new reductions in Medicare, Medicaid and other Federal funding sources, many hard-pressed state and local governments are struggling simply to maintain their current level of support, or are actually reducing that support.

Meanwhile, many of the safety net hospitals are facing negative operating margins, even with substantial local subsidies; some are finding it harder and harder to recruit staff or afford necessary maintenance of plant and equipment and stand in immediate danger of losing accreditation; and some are seeing their bond ratings downgraded, while others are finding it difficult to gain access to capital for needed renovations, equipment and new services. It is somewhat encouraging, Mr. Chairman, that we are once again publicly debating possible ways to close the enormous gaps that leave 31 to 37 million Americans without adequate insurance. Until those gaps are finally closed, however, it is imperative that you recognize that a very small handful of hospitals are carrying the majority of this burden—are serving, in effect, as our national health insurance by default. And these hospitals will continue to need your active and aggressive support this year, even as you debate the understandable need to meet deficit reduction targets for the coming fiscal year.

In the remainder of my testimony this morning, I would like to provide you with some detailed current information in several of the areas outlined above, by way of support for your continued efforts to protect our nation's safety net hospitals.

First, I will describe in greater detail the current situation of major, metropolitan area safety net hospitals nationally, including the characteristics that distinguish these hospitals from the average American hospital. In this section, I will also describe the disproportionate impact on such hospitals of current health industry problems, such as increased demand for uncompensated care, the nursing shortage, AIDS, and the growing crisis in trauma and emergency care.

Second, I will discuss current sources of financing for the essential services provided by these hospitals, through a fragile combination of Federal, state, and local governmental funding.

Third, I will address the specific impact of recent Medicare reimbursement policies and reforms on metropolitan area safety net hospitals, and the potential impact of new policies that have been proposed by the Administration, the Inspector General, the General Accounting Office and ProPAC.

Fourth, I will discuss the importance of Medicaid and need for expansions in this program.

Finally, I will conclude with several summary recommendations for the Subcommittee as you move forward with your deliberations this year.

I. THE SITUATION OF URBAN PUBLIC HOSPITALS NATIONALLY

Increased attention has been paid in recent years to the valuable hospital network that serves as the safety net for America's health system. This network is comprised of a surprisingly small group of hospitals in our nation's metropolitan areas—perhaps no more than two or three hundred in all, out of over 6,000 hospitals nationally.

While there are a number of non-profit teaching and community hospitals within his network, the majority are government-supported facilities. These include city and county hospitals, state university hospitals, and hospital districts and authorities, in addition to non-profit facilities.

While these safety net hospitals operate under a variety of legal structures, they share a common mission and many common characteristics that set them apart from other community hospitals. These hospitals provide a significantly higher

volume of inpatient and outpatient services than their private sector counterparts; they have seen increases in occupancy rates while the hospital industry in general has seen occupancy rates fall; they provide many unprofitable specialized services; and they are major educators of our nation's physicians and nurses. They are funded to a much greater degree than other hospitals by governmental sources (local, state and federal), and typically have a much lower proportion of privately insured patients. They continue to bear an enormous and increasing share of the burden for care to the poor in comparison to other segments of the hospital industry.

The information 1 will present describes the distinguishing characteristics of these safety net hospitals, drawing on 1988 data from our 1989 NAPH survey. While this data relates only to NAPH member hospitals, we believe our sample is sufficiently large (approximately So hospitals responding to our survey, with gross revenues in excess of $8 billion) to enable you to draw some conclusions about this segment of the industry as a whole.

A. Volume of Services

Although NAPH member hospitals are few in number, they provide a huge volume of care, and that volume continues to increase. In 1988, NAPH hospitals averaged 18,671 admissions per hospital, while other short-term acute care hospitals in the same metropolitan areas averaged only 7,038 admissions per hospital.

NAPH members also provide a disproportionate share of outpatient services, averaging over 242,000 visits per hospital in 1986, compared with other urban community hospitals, which averaged only 50,414 visits per hospital. By 1987, NAPH hospitals were averaging over 278,000 visits per hospital and by 1988 over 300,000 visits per hospital as compared to 60,155 visits for other urban community hospitals.

Member hospitals averaged 3,507 births per hospital in 1988, while other short-term urban hospitals averaged just 815 per hospital. Our members experienced almost twice as many surgical cases than did other community hospitals, averaging 8,350 cases in 1988 as compared to 4,950 for other short-term community hospitals.

B. Occupancy Rates

Another striking difference between NAPH member hospitals and other community hospitals is illustrated by hospital occupancy rates, and by the continued increase in these rates at a time when occupancy rates in the rest of the industry have gone down. The AMA reports that occupancy rates for community hospitals have been declining, from 75 percent in 1975, to 69 percent in 1984, and to 66 percent in 1988. For NAPH hospitals, however, the rates have been considerably higher and remain so. In 1988, occupancy rates for NAPH members averaged 81%.

C. Trauma Care and Other Specialized Services

In addition to providing care to the poor, NAPH hospitals also provide many specialized services that are unprofitable and, consequently, are not offered by many other hospitals in the community. For example, NAPH hospitals are more than four times more likely to be designated a trauma center than private facilities. Seventy-two percent (72%) of NAPH member hospitals are designated as trauma centers, while only about 13 percent of other short-term acute care hospitals provide this service. As you are aware, hospitals in some parts of the country are now dropping their trauma center designations and are even seeking ways to curtail their emergency room services.

Fifty-three percent (53%) of NAPH hospitals have a designated burn center, while only three percent of other community hospitals have such designations. Eighty-three percent (83%) of NAPH members provide neonatal ICU services, as compared with only 13 percent of other community hospitals. Forty-four percent (44%) perform open-heart surgery, compared to 15 percent of other hospitals. NAPH hospitals are also more likely to offer psychiatric services: 72 percent offer inpatient psychiatric services, as compared with 26 percent of other hospitals.

The costs associated with the provision of these specialized services can be burdensome. For example, many inner-city trauma centers provide a high proportion of uncompensated care associated with gunshot-wound victims and other victims of violent crime. The cost of such treatment is high, and most often, patients have no insurance or other means to pay for it. A recent NAPH survey on trauma care showed that NAPH hospitals collected an average of 45 cents on the dollar for trauma patients.

D. AIDS

NAPH member hospitals have also been at the forefront of the AIDS epidemic, treating a disproportionate share of the AIDS population, and that burden is also

increasing. According to an NAPH study of the financing and care of AIDS patients in U.S. hospitals, NAPH member hospitals treated 55 percent of the AIDS patients included in the survey, but represented fewer than 25 percent of the beds. NAPH hospitals treated an average of 61 AIDS inpatients in 1985; by 1988, that average was up to 134 inpatients, for an increase of well over 100 percent. Just 58 NAPH member hospitals in 1988 treated almost 7,800 inpatients.

Outpatient services to AIDS patients increased even more dramatically. NAPH hospitals provided an average of 965 outpatient visits during 1985, and an average of 1,539 visits during 1987, for an increase of nearly 60 percent.

We have some dramatic statistics on the sources of payment for AIDS care. Only eight percent of AIDS patients in 1985 were covered by private insurance. Twenty-five percent (25%) were described as "self-pay" or "other" patients, a good proxy for non-paying patients. Sixty-two percent (62%) were covered by Medicaid (pointing to the importance of that program in the financing of AIDS care). Medicare covers only a small fraction of AIDS patients—about one percent. In all, 92 percent of the AIDS patients treated in public hospitals were supported by some kind of government program or funding (since local governments in effect pay for the non-paying patients).

Data from 1987 indicate that the percent of Medicaid payments has decreased to 54 percent, and the self-pay/other sources of financing have increased to 33 percent. Private insurance represented nine percent of admissions and Medicare was up very slightly to two percent.

E. Drug and Alcohol Use

NAPH hospitals are also treating an increasing number of cocaine-involved infants. In 1988, 43 NAPH hospitals treated an average of 104 cocaine-involved neonates; in the first half of 1989, these hospitals cared for an average of 61 babies.

The average length of stay for these infants is 7.8 days. However, hospitals reported that on average, infants remained an additional 76 days per year because appropriate placement was not available.

NAPH hospitals also provide a significant amount of care for drug and alcohol abuse including care for cocaine-involved infants. Fifteen NAPH hospitals reported a total of 68,739 outpatient visits where drug use was the primary diagnosis, an average of 4,583 visits per hospital. Thirty-eight percent (38%) of NAPH hospitals have outpatient alcohol services, and 15 hospitals have inpatient alcohol units. These units average 17 beds and 4,900 patient days per hospital.

F. Medical Education

NAPH members have maintained their commitment as major teaching hospitals, as well, with member hospitals averaging 184 residents per hospital in 1986, with an average ratio of .36 residents per bed. (The Council of Teaching Hospitals considers a ratio of over .25 to be a major teaching commitment.)

G. Care to the Uninsured and Underinsured

Although all of the characteristics outlined above distinguish safety net hospitals from other health care providers, it is their open doors for the medically disenfranchised that make these hospitals particularly vulnerable to Federal budget reductions. The financial and programmatic situations of these hospitals have been affected by several factors, including increases in the medically needy population, decreases in Medicare coverage of costs, and declines in Medicaid coverage.

In 1985, NAPH hospitals averaged 167,184 inpatient days per hospital, of which 42,877, or 25.65 percent, were considered unsponsored care. By 1987, unsponsored care represented over 28 percent of patient days (an average of 51,788 uncompensated days out of 180,052 total days per hospital). In 1988, unsponsored care represented 34 percent of all discharges and 29 percent of all inpatient days.

On the outpatient side, NAPH hospitals averaged 278,463 visits per hospital in 1987, of which 116,136, or 42 percent, were unsponsored. Fifty-two percent (52%) of all outpatient visits were uncompensated.

For some individual hospitals, the percentages of unsponsored care were much higher. For the San Francisco General Hospital, for example, unsponsored care represented 62 percent of all inpatient days and 72 percent of all outpatient visits in 1988. Parkland Memorial Hospital in Dallas reports that uns00nsored care accounted for 54 percent of inpatient days and 62 percent of outpatient visits in 1988.

H. Health Personnel Shortages

NAPH hospitals are among the biggest losers in the current nursing and manpower shortages being experienced in today's health care marketplace. The nation-

wide nursing shortage has forced safety net hospitals to allocate relatively more of their scarce resources to nursing salaries.

A 1988 NAPH survey showed that 49 safety net hospitals had an average 16 percent vacancy rate for registered nurses. Hospitals nationwide had a 11.3 percent vacancy rate, according to the AMA. These statistics, in combination with the above-mentioned increases in occupancy rates for public hospitals, point out a severe problem that needs to be addressed at the Federal level.

According to the NAPH survey, the RN shortage in public hospitals is made worse by a lack of funding, making it difficult to compete with private sector wage increases and bonuses. In addition, 41 percent of responding hospitals indicate that the types of patients they serve and the level of services they provide also hinder recruiting efforts. (These factors apply to recruitment of physicians and other health professionals, as well as nurses.)

II. FINANCING OF CARE

A. Sources of Revenue

Payments for the care of low-income patients, through Medicare, Medicaid and city, county, and state funds, continue to represent the major source of revenue for large urban public hospitals. In 1988, private insurance represented only 16 percent of gross revenues and 17 percent of the net revenues for NAPH hospitals. Funds for the treatment of low-income patients represented 50 percent of net revenues, at an average of $66.28 million per hospital ($37.36 million for Medicaid and $28.92 million for local/state funds).

Although Medicare payments (at 18 percent) represent a relatively smaller portion of the total revenues in major urban public hospitals than in the private sector, Medicare nevertheless represents a substantial proportion of the "insured" patient population and, therefore, Medicare payment policies are extremely important to safety net hospitals.

For this reason, the Administration's proposals to restrain PPS update factors reduce the indirect medical education adjustment, and reduce payments for capital costs and are likely to have a seriously disproportionate impact on NAPH members.

While recent increases in the disproportionate share hospital adjustment have been invaluable to NAPH members, as the data I have presented clearly indicates, Medicaid payments are also extremely important. Teaching programs in urban public hospitals, for example, are essential to patient care for *all* safety net patients, and especially the poor. Medicaid capital payments are also particularly important, because access to capital is usually far more constrained for 'safety net" hospitals. These issues will be addressed in greater detail below.

It is important to note that when Medicare payments do not keep pace with costs, the local governments that own public hospitals must make up the shortfall. This is becoming an ever increasing strain; many local governments simply are unable or unwilling to make up this shortfall.

B. Operating Margins

A very important indicator of a hospital's financial condition is its overall operating margin, or revenues over expenses. The typical NAPH hospital has had and continues to have a negative margin, a result of revenues inadequate to cover costs of care.

Forty-eight percent (48%) of NAPH member hospitals reported a deficit in 1985. For those hospitals with a deficit, the deficit averaged $24.48 million. By 1987, there had been a small improvement in the deficit situation among NAPH members. However, the average margin was still negative. NAPH members reported averaged revenues of $117.76 million per hospital and average expenses of $123.96 million. The average margin was −$6.26 million or −5 percent. In 1988, 59 percent of NAPH member hospitals reported a deficit, averaging $20.9 million for those with a deficit. Average operating expenses in 1988 were $142,758,000 and operating revenues of $133,774,000 for an average deficit of $8,984,000, or a margin of .7 percent. In spite of this small improvement, however, 48 percent of NAPH hospitals still remained in a deficit position, and the average deficit of these hospitals was over $14 million.

III. CHANGES IN MEDICARE PAYMENT POLICIES IN THE PRESIDENT'S BUDGET

The President's budget calls for cuts in payments to teaching hospitals and in capital cost reimbursement to hospitals that will together exceed $2.7 billion. I would like to address these issues and the problems that would result if such changes were made.

A. Medi al Education Adjustments

The President's budget proses that the Medicare payment adjustment for the indirect costs of graduate medical education be reduced from 7.7 percent to 4.05 percent, reducing Medicare payments by $1.03 billion. The budget also includes a new proposal to "reform" payments for direct medical education costs, reducing payments by $205 million in 1991.

The proposed indirect medical education cost reduction is exceedingly harsh and unrealistic in light of the costs facing teaching hospitals. The General Accounting Office ("GAO") has opined that the indirect medical education adjustment is too high (GAO/HRD–89–33). GAO, however, recommends a rate significantly higher than that proposed by the Administration. The GAO recommends that, without changes to the cost factors considered in calculating the adjustment, the indirect medical education adjustment should be set at 5.9 percent, the costs are measured more accurately. Prospective Payment Assessment Commission (ProPac) also disagrees with the President. Propac recommends the level be set at 6.8 percent.

The Association of American Medical Colleges ("AAMC') recently analyzed the impact of the various types of PPS payments on hospital margins and the effect of cutting the indirect medical education adjustment from 7.65 percent to 4.5 percent, as proposed by the President. The AAMC found that the DRG rate does recognize important differences in hospital costs, including the range of services offered by teaching hospitals and the socioeconomic mix of their patients. According to AAMC's analysis, a 50 percent reduction in the indirect medical education adjustment would reduce average PPS margins of teaching hospitals from one percent to −10 percent, not counting the disproportionate share adjustment, or −5.5 percent counting the disproportionate share adjustment.

Moreover, the impact of reductions in indirect medical education payments may lie exacerbated by changes in the reimbursement methodology for the direct costs of medical education. Since the Health Care Financing Administration only recently issued proposed regulations for implementing this statutory change, the impact of the new payment methodology is not yet clear. Thus, to avoid the potential for totally unmanageable financial distress, it may be wise to postpone any changes in the reimbursement for indirect medical education costs.

In summary, reaching a truly accurate figure with respect to the indirect costs of graduate medical education involves a complex interaction of variables (such as case-mix, location, and the effects of outlier and disproportionate share payments). I will not venture to suggest that a specific figure is correct or incorrect. Rather, I will assert simply this: urban public hospitals cannot withstand cuts in medical education payments without compensating adjustments elsewhere in the Medicare reimbursement scheme.

B. Capital Payments

In OBRA 1987, Congress reduced payments for capital costs by 12 percent (below costs) as of January 1, 1988, and by 15 percent in 1989. In 1991 the Secretary of Health and Human Services will be required to incorporate capital payments into the prospective payment system.

The President has proposed that capital costs be reduced even more drastically in 1991—to 25 percent below costs for urban hospitals, and 15 percent for rural hospitals. While the impact of these reductions would not be as great as that resulting from cuts in indirect medical education reimbursement, they are still significant for urban public hospitals.

NAPH members and other metropolitan public hospitals have special concerns regarding capital cost reimbursement because the average age of their plants is significantly greater than that of other hospitals. Capital improvements, including modernization of equipment, have been unaffordable to most urban public hospitals. Because of their relatively low level of privately-insured patients, as noted above, such hospitals are uniquely reliant on government payors in their effort to gain access to capital. Yet renovations and improvements must be made. At this point, the situation is getting desperate for many safety net facilities.

Dr. Sullivan's statement, therefore, that cuts in capital payments create a "genuine incentive" for hospitals to re-evaluate their construction and expansion plans is overly optimistic in its assumptions. For NAPH members, it is not a matter of re-evaluation. It is a question of how to find capital to make critically necessary improvements.

I urge you to keep the situation of these hospitals in mind when considering any changes in the reimbursement for capital costs. In addition, we will be asking the Congress later this year to consider taking positive steps to assist such safety net hospitals in gaining access to capital.

C. The Disproportionate Share Adjustment

As I mentioned above, the Medicare disproportionate share adjustment has been essential for our nation's urban public hospitals, and has been an effective way to target Medicare funds where they are needed most. From the information presented earlier, there should be no doubt that these hospitals require this adjustment, in support of the vital role they play in caring for the nation's low income elderly and other poor, and in providing essential specialized services to all citizens.

IV. IMPORTANCE OF MEDICAID

We also urge this Committee to maintain and improve access to hospital services for persons covered by Medicaid. Congress has recognized that adequate payment is an essential part of ensuring the availability of Medicaid services and the survival of urban, public hospitals that care for large numbers of indigent patients.

As I have stated, urban public hospitals are highly dependent on Medicaid revenues. Nevertheless, Medicaid payments continue to be inadequate to cover the casts of treating such patients. Inadequate payment rates for inpatient services in many states, and even lower outpatient rates are resulting in fewer and fewer providers baring an ever growing burden of Medicaid shortfalls. Services are increasingly threatened, and many emergency care networks are collapsing.

First, minimum standards should be enacted for Medicaid disproportionate share payments. While states are required to provide for such payments, in many oases, these are so low as to be meaningless. In light of the financial burden of charity/indigent care, Congress should require states to provide meaningful Medicaid disproportionate share payments.

Second, providers of AIDS services are in desperate need of increased Medicaid support, especially in the face of a doubling caseload of AIDS patients over the next year. Systems of care are about to collapse and the President's budget offers no assistance. Exacerbating this problem are pediatric AIDS admissions which tend to lengthier and more frequent than adult admissions. AIDS is becoming a disease primarily of the medically disenfranchised, including the uninsured, underinsured, poor children and drug users. Since a major concentration of persons with AIDS are being treated in a handful of urban hospitals, these hospitals will be pushed into financial ruin unless Congress authorizes Medicaid payment adjustments for hospitals treating a disproportionate share of AIDS patients. To avert disaster for these and other providers, Congress must also expand Medicaid coverage of home and community-based AIDS services to reduce unnecessary hospital admissions and establish a Medicaid AIDS prevention program which will cover preventative drugs, such as AZT, and other outpatient services for HIV-positive individuals. Only with these and other measures will our health care system be able to meet the formidable challenge that the AIDS epidemic poses in the 1990's.

Third, Congress must permit states to take advantage of all available sources of revenues in meeting present and future Congressional mandates to expand eligibility and services, and improve payments. This includes in particular the unfettered ability to make use of funds voluntarily donated by hospitals and other providers, with appropriate restrictions. Such donations may currently be used, but HCFA has issued proposed regulations that would do away with this essential program. The Congress has clearly recognized the need for donated funds by enacting prohibitions in 1988 and 1989 against such regulations. We now urge the Committee to make such prohibition permanent.

Fourth, fixed durational limits for medically necessary inpatient hospital services should be prohibited. Additionally, general or institutional volume caps which would have the effect of limiting medically necessary days or resulting in arbitrary reductions in established payment rates for days exceeding such caps should not be allowed. Such caps have the effect of inappropriately forcing the subsidization of indigent care by hospitals already operating at the margin.

Fifth, outpatient reimbursement should be improved. States should be required to provide for an adjustment for payments for outpatient services provided to individuals by disproportionate share hospitals. Also limits on medically necessary covered outpatient services provided to individuals in disproportionate share hospitals should be prohibited.

Sixth, outlier adjustment should be required under state prospective payment plans for medically necessary inpatient hospital services for very high cost or exceptionally lengthy cases.

V. ILLUSTRATIONS

In this section of my testimony, I would like to illustrate the general characteristics and observations set out above by describing the current situation of two particular urban safety net hospitals.

Parkland Memorial Hospital, in Dallas, estimates that its average Medicare inpatient payment would be reduced by $948 per admission if the President's reductions were implemented—$699 for indirect teaching, $160 in the medical price index, and $89 for reducing the capital payment from its current 85% to 75%. Medicare losses would total $3.7 million for Parkland, based on approximately 3,500 Medicare admissions (9% of all admissions).

Miami's Jackson Memorial Hospital would lose approximately $960 per discharge, of which $820 would be medical education payments, $91 for the medical price index shortfall, and $49 for capital. Jackson Memorial also expects about 3,500 Medicare admissions, or 6% of their total, and estimates their Medicare loss at $3.4 million.

Neither these hospitals, nor the 200 other urban safety net hospitals like them, can afford such reductions in reimbursement.

VI. RECOMMENDATIONS

While we acknowledge that the committee is only beginning to consider its legislative agenda for this session, we believe it is important to set concrete goals early on if they are to be achieved in an era in which the budget deficit is such an overwhelming concern.

In forthcoming budget debate, we urge you to pay careful attention to the impact of the indirect teaching and disproportionate share hospital adjustments on our most vulnerable safety net hospitals.

We further urge your continued careful consideration of legislation to mandate minimum health benefits. In the interim, the time may also be ripe to extend and expand an idea that has been proposed in the past: the creation of a national indigent care trust fund, and the financing of that fund from insurance premiums taxes, alcohol and tobacco taxes, and other potential revenue sources. We would be pleased to assist you in the design of such a program.

We expect also to invite your continued attention this year to narrower, but equally important, issues such as improving access to capital for urban and rural safety net providers; preserving and protecting Medicare bad debt payments, outliers, and outpatient payments.

Finally, you should be aware that, in the forthcoming debate over the most appropriate methods of reducing the deficit—with all due respect to the campaign promises of President Bush—you will have the support of at least this segment of the industry if you choose to raise taxes to offset at least a part of the deficit.

STATEMENT OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

The National Conference of State Legislatures is concerned about the President's proposal to extend the Medicare and Social Security coverage to State and local government employees. NCSL is a non-partisan organization created to serve the legislators and staffs of the Nation's 50 States, its commonwealths and territories.

We in the Nation's State legislators understand the urgent need to address the Federal budget deficit, and we support your responsible efforts to do so. We know that several of the President's proposals will have a significant fiscal impact on the States. Of the $13.9 billion additional revenue in the President's budget, a significant portion is proposed to be directly contributed by State and local governments. We urge you to reject any measures that would disrupt intergovernmental fiscal relations and impair the ability of State governments to meet their responsibilities to our shared constituencies. Eliminating the deficit is important to all of us, but shifting the fiscal problems from one level of government to another is not the solution.

An example of shifting the burden to the States is the agreement made between the Federal and State governments in the 1985 consolidated omnibus budget reconciliation act. In response to the Federal Government's pressing need for revenues, Congress enacted "cobra" which requires public employers to phase-in Medicare hospital insurance coverage for all State and local government employees hired after April 1, 1986. Through normal job attrition, Congress assured itself that all public employees will ultimately pay the full Medicare tax to the Federal Government. Similarly, the phase-in provision allowed State and local governments time to adjust their budgets for this additional tax. However, in order to offset the budget deficit, the administration now proposes to impose mandatory Medicare coverage for

all State and local government employees notwithstanding the phase-in agreement. This clearly abrogates the commitment made by the Federal Government to the States. It also serves as yet another example of the attempts to export the Federal budget deficit to State and local governments.

The change in coverage, proposed to be effective October 1, 1990, is estimated to increase receipts to the hospital insurance trust fund by $1.7 billion in fiscal year 1991. The proposed extension would add an immediate expense to individual State budgets ranging from an estimated $300 thousand to $263 million annually. For example, the fiscal impact for the State of Texas would be $129 million. As you are well aware, the fiscal climate in Texas remains extremely tenuous, as is the case for many States. The extension of the Medicare payroll tax will be one more fiscal burden that will aggravate our budget process and will strain our ability to provide services to the public, including services the Federal government mandates.

This additional tax on public employees and employers would especially disrupt the fiscal health of at least 10 States. These State are: California, Colorado, Florida, Illinois, Louisiana, Massachusetts, Minnesota, New York, Ohio, and Texas. While the impact of the proposal would fall most heavily upon governments in these ten States, forty-nine States have some non-covered employees which would impact their operating budgets as well. The attached table (prepared April 1989) estimate the cost of extended coverage on a State-by-State basis.

Federal revenues raised by coverage of these new employees have already been collected by congress under "cobra" and are included in budget allocations. As a result of job attrition which averages 9 percent per year, the revenues in the outyears will decline substantially and ultimately will decline to zero. At best, the mandatory Medicare coverage proposal will provide only a quick fix to deficit reduction and will do nothing to reduce the structural deficit. Meanwhile, the States will be faced with an immediate tax burden which many cannot afford to pay.

Another example of fiscal burden placed on the States is the President's budget proposal to require State and local government employees, not covered by a public employee retirement program, to participate in the Social Ssecurity system. This change in coverage would be effective for October 1, 1990 and is estimated to increase receipts in the OASDI trust fund by $2.1 billion for fiscal year 1991. These revenues would be used to offset the costs of various spending proposals and would be part of the $13.9 billion in revenues recommended by the administration for fiscal year 1991.

According to the President's budget, approximately 3.8 million workers not covered by a public employee retirement plan would be required to participate in the Ssocial Security system. Most of these workers are part-time or temporary employees, and in many cases, least able to pay an additional tax. The issue here is revenue raising, not sound policymaking. Equally important, the revenue proposal would impose significant additional costs upon State and local government employers. Half of the amount this proposal would raise would come straight from the treasuries of State and local governments in the form of the employer's share of the FICA tax. Those States that would be significantly impacted are: Alaska, Colorado, Louisiana, Maine, Massachusetts, Nevada, and Ohio.

Finally, the additional revenues raised would actually accumulate in the Social Security trust fund. As you well know, trust fund surpluses are included in the calculation of the Federal budget deficit, thus offsetting total government expenditures and masking the true size of the Federal deficit. Therefore, any additional revenues collected would not necessarily contribute to future Social Security payments. In addition, funds from current Social Security surpluses as used to purchase Treasury bonds, thus lowering the cost of borrowing to governments rather than saving money for future claims on the fund.

We in State government stand ready to bear our fair share of the burden in the effort to reduce the Federal budget deficit, a position that NCSL has reiterated throughout the previous decade. However, over these last ten years, State and local government have experienced a disproportionate share of the Federal spending cutbacks and simultaneously have been handed a growing number of underfunded or unfunded Federal mandates. An immediate extension of the Medicare and Social Security coverage to all State and local government employees is clearly a Federal mandate that States should not have to bear.

TABLE B

April 1989

POTENTIAL ANNUAL COST TO STATE AND LOCAL GOVERNMENTS OF COVERAGE OF THOSE EMPLOYEES CURRENTLY NOT COVERED BY MEDICARE

State	Employees not covered by Social Security/1	Employees not covered by Medicare Number/2	Percentage/2	Cost of Coverage (in millions of dollars)/3
Alabama	27,000	19,710	8.2	7.2
Alaska	40,000	29,200	51.5	10.6
Arizona	21,000	15,330	8.2	5.6
Arkansas	39,000	28,470	9.7	10.3
California	991,000	723,430	47.1	263.0
Colorado	150,000	109,500	56.7	39.8
Connecticut	63,000	45,990	27.6	16.7
Delaware	14,000	10,220	25.4	3.7
Florida	127,000	92,710	15.7	33.7
Georgia	64,000	46,720	13.5	17.0
Hawaii	24,000	17,520	29.7	6.4
Idaho	0	0	0	0
Illinois	299,000	218,270	39.9	79.3
Indiana	54,000	39,420	12.7	14.3
Iowa	5,000	3,650	1.5	1.3
Kansas	2,000	1,460	0.7	0.5
Kentucky	56,000	40,880	20.7	14.9
Louisiana	271,000	197,830	63.4	71.9
Maine	52,000	37,960	53.0	13.8
Maryland	29,000	21,170	7.5	7.7
Massachusetts	334,000	243,820	74.6	88.6
Michigan	19,000	13,870	3.0	5.0
Minnesota	96,000	70,080	24.7	25.5
Mississippi	2,000	1,460	0.7	0.5
Missouri	62,000	45,260	16.4	16.5
Montana	5,000	3,650	6.7	1.3
Nebraska	2,000	1,460	1.5	0.5
Nevada	49,000	35,770	70.2	13.0
New Hampshire	6,000	4,380	7.5	1.6
New Jersey	30,000	21,900	4.5	8.0
New Mexico	33,000	24,090	20.1	8.8
New York	153,000	111,690	8.9	40.8
North Carolina	43,000	31,390	8.3	11.4
North Dakota	6,000	4,380	7.5	1.6
Ohio	599,000	434,390	74.0	157.9
Oklahoma	33,000	24,090	11.2	8.8
Oregon	14,000	10,220	5.2	3.7
Pennsylvania	38,000	28,200	4.9	9.0
Rhode Island	25,000	18,250	32.1	6.6
South Carolina	8,000	4,380	2.3	1.6
South Dakota	2,000	1,460	3.7	0.5
Tennessee	29,000	21,170	8.9	7.7
Texas	486,000	354,780	37.3	129.0
Utah	1,000	730	0.7	0.3
Vermont	1,000	730	1.5	0.3
Virginia	72,000	52,560	13.5	19.1
Washington	38,000	28,200	9.7	9.0
West Virginia	7,000	5,110	4.5	1.9
Wisconsin	48,000	35,040	11.5	12.7
Wyoming	5,000	1,650	7.5	1.3
TOTAL	4,564,000	3,331,720		$1211.2

1/ Social Security Administration, 1988 Current Population Survey and Continuous Work History Sample. reprinted in Congressional Research Service paper "Medicare Coverage of Employees of State and Local Governments;" by David Koitz, (March 17, 1987).

2/ The Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272, requires public employees hired after March 31, 1986, to participate in the Medicare system. Because we assume employee turnover occurs at a rate of approximately 5% per year, in the three years since COBRA took effect, approximately 27% of previously non-covered public employees are now covered by Medicare. The number of public employees not covered by Social Security has therefore been reduced by 27% to reflect the number of employees who are currently not covered by Medicare.

3/ The figures reflect only the 1.45% that would be paid by the governments as employers, and do not include the cost increase to their employees, who would also have to pay the 1.45% Medicare tax (or reverse side for increased tax burden on individual employees). Given that the employer's part of the Medicare tax is 1.45%, and the salary of the average state or local government employee is $25,368 (U.S. Bureau of the Census, Public Employment in 1987 - Government Employment (Series GE-87-No. 1), p. 10), each governmental employer's cost is equal to the number of employees, multiplied by $25,368 multiplied by 1.45%.

STATEMENT OF THE NATIONAL CUSTOMS BROKERS AND FORWARDERS ASSOCIATION OF AMERICA, INC.

On behalf of the National Customs Brokers and Forwarders Association of America (NCBFAA), I wish to express our opposition to the President's budget proposal to increase the harbor maintenance fee to .125%

This ill-conceived "fee" began as a tax to defray some of the costs of dredging the nation's harbors. A fee of .04 is assessed on the value of cargo imported, exported or shipped domestically on U.S. rivers and inland waterways. NCBFAA opposed the fee when it was first proposed and we oppose it now, since it is a tax imposed on a very small segment of the public to fund what clearly is a government function.

Our opposition is also directed at the fee's inherent complexity—a complexity which leads to inconsistent results and mass confusion for the trading community. For example, certain commodities such as fresh fish caught in international waters are exempt. Cargo entering ports not maintained by the Corps is exempt. And, merchandise in transit across the U.S. for export is exempt, while domestic cargo shipped on U.S. rivers and inland waterways is subject to the fee. This means a shipment from, say, Memphis to New Orleans will be assessed the harbor maintenance fee since that shipment is a domestic movement of cargo. Then, the fee will again be assessed when the same cargo is loaded onto the ship in New Orleans for export.

Now the President is asking Congress to go a step further to *triple* the harbor maintenance tax so it can pay for all of the costs associated with the Corps' harbor maintenance dredging (instead of the current 40%), along with the full cost of certain National Oceanic and Atmospheric Administration marine programs. This proposal is unacceptable. To saddle importers and exporters with this additional burden is a short-sighted and dangerous approach to achieving deficit reduction—an approach which Congress should reject out of hand.

An increased harbor maintenance tax poses a serious impediment to U.S. exports—at a time when the trade imbalance is disturbingly high. While the government preaches "competitiveness" themes on other fronts, it seems incongruous to even think about hitting exporters with a .125 tax on the value of their cargo. And for imports, a harbor maintenance tax increase represents one more non-tariff barrier to trade, further eroding our country's position in negotiating tariff concessions from our trading partners at a critical time in our international negotiations.

Added to this, an increase in the harbor maintenance fee will only make the fee's complexities all the more glaring. Many exporters and shippers are already baffled as to how and when it applies, leading to uneven compliance. The compliance problem is heightened by the fact that the fee is very difficult to collect. In fact, collection of the fee on exports and domestic shipments is dependent on a quarterly reporting scheme which not only has horrendous recordkeeping requirements, but which as a practical matter can be easily ignored. Unlike the fee on imports, which is collected as part of the regular Customs entry process, payment of the fee on exports and domestic shipments is not tied to any administratively enforceable procedure to ensure compliance.

These features have engendered a widespread disregard of the fee—both intentional and unintentional. Customs knows this, but they have concluded that the cost of auditing exporters would exceed the amount to be collected. The sad result is that the informed, law-abiding shippers are footing the bill for the dredging of our harbors, while scofflaws turn their heads. Now, the Administration wants this burdensome discrepancy enlarged.

Finally, we hear from our northern border customs brokers and ocean freight forwarders that shippers are increasingly selecting Canadian ports, where no fee is required. In an environment where collection and enforcement are weak, and respect for the fee is low, avenues for non-payment and avoidance, such as this, simply multiply.

Mr. Chairman, we urge you to oppose any increase in the harbor maintenance fee. And, we ask that your Committee take a close look at the fee itself—at how it is administered and how it works in practice. In doing so, NCBFAA believes you will conclude as we have that the harbor maintenance fee should be repealed, not increased.

STATEMENT OF THE NATIONAL TRADE ASSOCIATIONS

DESCRIPTION OF THE ASSOCIATIONS

The Alliance of American Insurers, the American Insurance Association, the National Association of Independent Insurers, the National Association of Mutual Insurance Companies and the Reinsurance Association of America ("the Associations") are voluntary, non-profit, national trade associations which together represent approximately 2,000 property and casualty ("P & C") insurance companies that write more than 80% of the premium volume with respect to property and casualty insurance risks written in the United States.

The Associations' members include P & C companies of all types, including stocks, mutuals, reciprocals and Lloyds, primary writers and reinsurers—ranging in size from small one-state writers to large multi-state companies. They do business in every State and virtually every community in the nation. These large and diverse memberships provide a strong voice representing the broadest range of views on major issues.

THE PROPOSAL

P & C insurance companies are subject to regulation by insurance departments in the various States in which they do business. Under accounting rules adopted by the States, at the time an insured loss occurs a P & C insurer is required to establish a reserve to pay that loss. The reserve must be sufficient to cover the full amount the P & C insurer expects to pay. With respect to certain coverages, an insurer that pays a loss may be entitled to recover as salvage the damaged property with respect to which the loss was paid. In other instances, the insurer may have subrogation rights against third parties. Under State regulatory accounting procedures, the P & C company is generally not entitled to recognize these potential salvage and subrogation recoveries until they have been reduced to cash or cash equivalents. For purposes of computing their tax liability, P & C companies have for many years been required to follow regulatory accounting requirements with respect to these items. However, as part of the Revenue Act of 1986, P & C insurers were required to discount their deduction for loss reserves.

The President's Budget for fiscal year 1991 proposes that section 832 of the Code be amended to require that, in taxable years beginning after December 31, 1989, the deduction allowed P & C insurers for losses incurred be reduced by an estimate of salvage (including subrogation claims) they will recover in the future. Treasury would be given regulatory authority to provide for the discounting of any salvage to be taken into account. The opening adjustment, equal to the difference between loss reserves unreduced by estimated salvage recoveries at the end of 1989 and loss reserves reduced by salvage at the beginning of 1990, would be included in income over a period not exceeding 4 years.

REASONS THE ASSOCIATIONS OPPOSE THE PROPOSAL

The Associations object to the proposal for the following reasons:

1. The Proposal Will Undermine State Regulation for Insurer Solvency.

The proposal is based on the express assumption that if liabilities for insurance *losses* are allowed to be estimated, potential salvage *recoveries* should also be estimated. This assumption is squarely at odds with, and would undermine the integrity of, the long-standing regulatory requirements which have been designed by the States to help assure the solvency of P & C insurers and which have been embodied in the income tax law for more than two-thirds of a century. That concept recognizes that salvage is not to be taken into account until it is "in course of liquidation," i.e., until property rights have become fixed and are in the process of being turned into cash.

The fundamental premise underlying these regulatory requirements is that a P & C insurance company should not be allowed to count as income—to do with as it pleases amounts that have been paid in for the benefit of policy claimants until it is clear that those amounts will not be needed to protect claimants. Stated differently, a P & C insurance company's income should consist only of what is left over after fully providing for policy claims. To achieve this end, P & C insurance companies are required to estimate and reserve for major liabilities, so that policy claimants will be protected. To the same end, income items are not to be counted until they are "solid," i.e., until it is virtually certain that they will be collected. Therefore, under state regulatory requirements and under the present tax law, salvage recov-

eries may not be estimated but must be "firmed up" before counting them as income.

If potential salvage were to be treated as a reduction of the company's liability for losses or as an asset, the result would be, in effect, to include it in income. The company would be able to count an equal amount of assets as its own, leaving the policy claimants, to that extent, with a mere hope rather than solid assets backing up their claims. And if the tax law were to be changed to treat these speculative items of recovery as income—perhaps 10 years in advance of their receipt—the result would be to further undercut the integrity of regulatory accounting requirements to the detriment of the interests of policy claimants. In an era of escalating P & C insurance company insolvencies, such a result is unwise and perverse.

2. The Proposed Treatment of Salvage Is Contrary to the Treatment of Other Taxpayers.

Nowhere in the Tax Code is a business taxpayer required to take a mere hope or expectancy of income indeterminable in amount into account in computing its taxable income. More is required. Yet that is what in effect is being proposed for P & C insurers. At the time a loss occurs, the insurer has an immediate obligation to reimburse the insured or the insured's victim, but the insurer has no right to salvage that may be recovered with respect to that loss—it has no immediate right to the wrecked auto. It is well settled law that the right arises, if at all, only when the related loss is paid. But payment of the loss only begins the process. Salvage property needs to be identified, located and valued; not only must title be obtained, but existing title may be in dispute. In the case of subrogation, both the entitlement to and the amount of subrogation against a third party or another insurer may be in dispute and indeterminable for years, even after the loss is paid. The proposal glosses over the taking of income into account while it is only a hope by treating it not as income but as a reduction of a liability. But the end result is the same, and it is contrary to what is required for other taxpayers and is directly at odds with the regulatory accounting system that has been designed and is utilized to protect the solvency of P & C insurers.

3. The Proposal Would Cause Unnecessary Complexity Out of All Proportion to the Projected Revenues to Treasury.

The proposal would require a P & C company (unlike other taxpayers) to take salvage and subrogation into account as income before the company has any right to it, and then provides for discounting the amount because it is taken into account early. But why accelerate recognition of income and then make an adjustment for speeding up? If an adjustment is necessary to compensate for speeding up, the proper treatment is not to speed up, but to continue to recognize the income when actually received.

Speeding up income recognition would raise revenue for budget purposes, but that is an expedient, not an improvement. The proposal would accomplish little other than to run the industry around in a very expensive circle—speed up and then compensate for speeding up. And, under Treasury's own estimates it would raise very little revenue for Treasury (and much of it would consist of the one-time, opening balance adjustment). Simply stated, it makes little sense, economically or otherwise, to impose an expensive, time-consuming burden on the industry to make estimates of very uncertain recoveries when tax returns are filed and to justify those estimates on audit of such returns.

4. Implementation of the Proposal Would Require Use of Statistics That Do Not Exist, Would Be Enormously Expensive to Implement and Extremely Difficult to Audit for Compliance.

The proposal raises a host of practical issues, the answers to which are unknown, if not unknowable. Yet without such answers, the legislation cannot be sensibly drawn and P & C insurance companies will not be able to determine whether they are in compliance. For example:

a. If salvage and subrogation is to be taken into account early, it must be discounted (the Treasury proposal so contemplates). Discounting of loss reserves is presently provided for on the basis of historical patterns relating payment of losses to years in which such losses were incurred, as specifically shown in Annual Statements filed by all insurers with state regulatory authorities. Discount tables are computed by the Treasury (or, at the option of the taxpayer, from the taxpayer's own Annual Statements). In the case of salvage and subrogation, comparable historical data which would be necessary for discounting have never been included in the Annual Statements. As a result, Treasury

would not have the data from which to publish uniform tables. Taxpayers would have to develop their own data, and many companies have not kept records in a way that will permit them to reconstruct the receipt patterns required. The reconstruction, even were it possible, would vary from company to company, could not be checked against Annual Statement data and would surely be the subject of significant audit appeals and court costs for the government and taxpayers.

b. The recovery of salvage and subrogation typically results also in additional liabilities. If the salvage and subrogation is to be estimated in advance, so too must the associated liabilities be estimated. The principal lines in which there is major salvage and subrogation are auto physical damage ("Auto P.D.," covering losses to the policyholder's auto) and workers' compensation, with Auto P.D. being the largest by far. The relevant dollars are concentrated in subrogation. In the case of Auto P.D., subrogation recoveries, even when received, are often not kept by the company, but are paid in whole or in part to the policyholder to reimburse him for the policy deductible.

> (For example, on a $1,200 2-car accident loss under a $200 deductible policy, the insured's insurance company pays him $1,000. Five years later it is determined in a lawsuit that the other driver was responsible and his insurance company pays $1,200 for the damage, to which the original company is subrogated to the extent of $1,000. The remaining $200 is then returned to the policyholder).

The precise treatment of subrogation recoveries in such situations varies from state to state.

In the case of workers' compensation, most large policies contain provisions under which premiums are adjusted to reflect actual losses. If there is a subrogation recovery, the company may not keep it; rather, it is paid, in whole or in part, to the policyholders as a premium adjustment.

In still other cases, Auto P.D. policies combine these features.

There is little uniformity as to how much detailed data companies have kept with respect to such policies and as to how that detail is reported. Hence, these policies would add further layers of complexity in attempting to implement the proposal and audit the diverse records.

c. It has long been recognized by all concerned that regular IRS agents are not equipped to evaluate the actuarial work that goes into insurance company loss estimates in order to determine whether the estimates were "reasonable" (which is what the Code requires). Simplified rules evolved, operating from Annual Statement data, and after 30 years of controversy were finally worked out in a way generally agreeable to both the IRS and the P & C industry. Those rules will not work satisfactorily for loss estimates that contain discounted provisions for salvage and subrogation. Since the information necessary to audit discounted salvage and subrogation recoveries is not reported in the Annual Statements filed with state insurance departments, IRS revenue agents will be required to evaluate the company's actuarial work and the volumes of data behind that work. A whole new source of controversies will result.

5. The Industry's Tax Posture Should Not Be Further Revised So Soon After the 1986 Act Changes.

The 1986 Tax Reform Act has already placed new tax burdens on P & C insurance companies. All indications to date are that these burdens will far exceed the $7.5 billion in additional taxes for fiscal years 1987–1991 estimated by Congress at the time the 1986 Act was enacted. For example, a survey of P & C companies conducted by Price Waterhouse shows that the P & C industry's 1987 taxable income, before reduction by NOLs, increased by $9.5 billion as a result of the three P & C-specific provisions of the 1986 Act. Even after application of NOLs, the P & C industry's 1987 tax liability increased by $1.7 billion as a result of the three P & C-specific provisions. *(Survey of 1987 Federal Income Tax Liability of Property and Casualty Insurance Industry,* pp. iii, Price Waterhouse, April, 1989). Similarly, an analysis by the Insurance Services Office finds that "For 1987–90, the first four years that TRA 86 is in effect, the industry's tax bill will be $12.2 Billion—$7.8 Billion more than the industry would have paid under prior law." (ISO Insurance Series, *Tax Law Changes and Property/Casualty Insurers: A Comprehensive Analysis,* p. 1, September, 1989). While the precise impacts of the tax law changes are not yet known, it is clear they will be substantial. At least until the implications of the 1986 Act are better known, changes such as those proposed in the Budget should be rejected.

STATEMENT OF OPPOSE

Members of the Senate Committee on Finance, I am Robert J. Scott, secretary-treasurer of OPPOSE. OPPOSE is a Colorado corporation formed by teachers, firefighters, police officers, and other state and local government employees who have elected not to join the Social Security/Medicare system. The purpose of our organization is to assure the continued financial integrity of our members' retirement and health insurance plans by resisting congressional efforts to mandate Social Security or Medicare coverage of public employees. Our members are found in Alaska, California, Colorado, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, Ohio, and Texas. With respect to the issue of mandatory Medicare and Social Security coverage, the interests of OPPOSE are identical to those of the four to five million full-time public employees throughout the nation who remain outside the Social Security system.

BACKGROUND

In its budget for fiscal year 1991, the Administration again raises the proposal to raise revenues (estimated at $1.7 billion in 1991 by both the Administration and the Congressional Budget Office) by imposing mandatory Medicare coverage upon all state and local government employees who are not now covered by Medicare. This tired measure has been proposed nearly each year since 1986, when Congress enacted a phase-in of mandatory coverage by requiring coverage of newly hired state and local government employees. We believe that the compromise adopted in the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") should be respected and that our employees and retirees should not be visited by the same threat year in and year out. Therefore, and for the further reasons set forth below, we ask you once again to reject the proposal to mandate Medicare coverage of all state and local government employees.

The Administration also has included a new proposal—to raise revenues (estimated at $2.1 billion by the Administration and reestimated at $2.0 billion by the Congressional Budget Office) by imposing mandatory Social Security coverage upon all state and local government employees who are not covered by a public retirement plan. The affected employees include students at state colleges and universities, and part-time and temporary workers such as substitute teachers and seasonal park workers. As we describe below in more detail, this proposal constitutes a significant new tax upon the segment of society that can least afford it. Therefore, we urge you to reject this proposal as well.

I. PROBLEMS RAISED BY BOTH MANDATORY COVERAGE PROPOSALS

The President's budget proposals would exacerbate the problem of insufficient progressivity in the tax system and would reverse efforts to provide tax relief to lower-income individuals, instead imposing a significant new tax burden upon the segment of society that can least afford new taxes.

The proposal to impose mandatory Medicare coverage upon all state and local government employees would affect over 3 million Americans who earn an average salary of approximately $26,000, as well as their families. These individuals—primarily teachers, firefighters, police, and other public employees—can ill afford the burden of Federal taxes increased, on average, by $377 each year ($26,000 multiplied by the HI tax rate of 1.45% effective in 1990). For example, the average Illinois teacher makes approximately $29,638 annually, and spends all but $320 of that each year on necessities such as housing, groceries, health care, taxes, and other basic expenses. The proposed new tax of $430 would more than offset that amount, leaving such an individual unable to meet those expenses, let alone accumulate any savings.

At the time of passage of the Tax Reform Act of 1986, the Joint Committee on Taxation estimated that the Tax Reform Act provided taxpayers with incomes in the range of $20,000—$30,000 with a cut equivalent on the average to $220. Thus, to cite another example, in the case of the average government employee in Colorado (whose annual salary is $27,180), the new Medicare tax of $394 would result in a *net tax increase* of $174 annually. (See attached Table A setting forth state-by-state the cost of Medicare coverage to the affected individuals as well as the projected amount of his or her tax cut under the Tax Reform Act.)

The proposal to impose Social Security upon state and local government employees not now covered by a public retirement system would have a devastating impact. The vast majority of affected employees are students working part-time at state universities, seasonal workers such as park employees and highway road

crews, or part-time school employees such as substitute teachers, bus drivers, and cafeteria workers. Virtually all of these employees work for low hourly wages. None can afford to pay 6.2% of their income (the OASDI tax rate effective in 1990) in new taxes. For an employee working 1000 hours per year (the maximum amount allowed before joining the public retirement system is required in many jurisdictions) at $8 per hour, the President's proposal would extract $496 in new taxes from an annual income totalling $8,000.

Moreover, the President's proposals would exacerbate the problem of declining progressivity in the tax system and would undo recent congressional efforts to shift the Federal income tax burden from relatively low-income individuals to those with higher incomes. Data released by the Treasury Department in January of this year reveal that, as a result of the Tax Reform Act of 1986, taxpayers with adjusted gross incomes under $50,000 received a net tax cut of $9 billion between 1986 and 1987. Now the Administration proposes to raise revenues of $3.8 billion annually—*or 42% of the net tax cut received by all Americans with incomes under $50,000*—from public servants who generally make much less. Indeed, while 18% of that tax cut would be recouped by imposing Medicare upon employees whose incomes average $25,000 annually, a full 23% would come from a segment of the workforce who make the very least amount of income.

Using the receipts of the OASDI and HI trust funds to "reduce" the deficit merely masks the true magnitude of the Federal budget deficit and fails to recognize that these new revenues must be used to pay benefits in the future.

Over the past several months much attention has been focused on the inclusion of the assets of the Social Security trust fund in the calculation of the budget deficit. The concern is that these funds are being used to reduce the level of the deficit although they are intended to be used to pay Social Security benefits in the next century when the number of retirees increases significantly. While a number of proposals have been advanced to remedy this problem (and there is disagreement as to which is best), all sides appear to agree that including the Social Security trust funds in the budget calculation simply masks the true magnitude of the deficit.

The President's mandatory coverage proposals, if enacted, would simply contribute to this ill effect. While these proposals might provide short-term revenues to the OASDI and HI funds, these revenues must ultimately be used to pay benefits to the newly-covered individuals. At best, these proposals would simply contribute to the illusion of deficit reduction, further obscuring the magnitude of the deficit.

Moreover, beginning in 1993, the mandatory Medicare proposal would not even raise revenues that could be scored for deficit reduction purposes. While the Administration's budget states that this measure would raise $1.7 billion in fiscal §1993, and CBO provides revenue estimates through fiscal 1995, these estimates do not reflect the fact that, under the Social Security Amendments of 1983, 42 U.S.C. §911(a)(1), the HI trust fund will go off-budget for all purposes beginning in fiscal year 1993. While the Social Security trust funds (OASI and DI) were also scheduled to go off-budget at that time, the process was accelerated by Gramm-Rudman with the result that those trust funds were removed from the budget effective October 1, 1985. And while Gramm-Rudman included a giant loophole, providing that the receipts of these trust funds could be counted in calculating the deficit, no such exception was included with respect to the HI fund. Thus increases in Medicare revenues resulting from any expansion of coverage will not affect the calculation of the Federal budget deficit beyond fiscal 1992. This would also be true for Social Security trust fund revenues if those trust funds are removed from the budget for all purposes.

At worst, the proposal to expand mandatory Medicare coverage will lose revenues beginning in 1993, if enacted. As the President's budget reflects, the revenues raised must be offset by the amount of income tax lost. In this case, the amount is likely to be significant since the newly imposed Medicare taxes would be quite expensive for the affected state and local governments. In order to raise the new Federal tax of 1.45% of payroll as the employer's share (and possibly more, if required to raise salaries to reflect the tax newly withheld from their employees), state and local governments are likely to increase their income and/or property taxes. Because these amounts are deductible, the Federal government's revenues from the income tax will decrease. And when this loss is offset against zero (the amount of revenue increase that can be scored from the Medicare tax), the net result is a loss.

In theory, these problems could be eliminated by the stroke of a pen, simply by providing that the receipts and outlays of the Medicare trust fund would also be included in the calculation of the Federal deficit. Such a course would not be advisable, for several reasons.

First is the fact that including Medicare for purposes of deficit calculation would place Medicare benefits on the chopping block once again as means of potential deficit reduction. After substantial cutbacks in payments to hospitals and other benefits in recent years, questions are now being raised by many legislators concerning the availability and quality of care for many patients. These questions should be answered in the context of the debate on improving the quality of affordable health care. Keeping Medicare off-budget will reduce the temptation to cut benefits further in willy-nilly fashion in order to reduce the Federal deficit.

The second reason is that, at a time when legislators and the Administration are debating the best means of removing the Social Security trust funds from the deficit calculation, it would be a step in the wrong direction to begin including the Medicare trust fund. Because the receipts of the trust fund are dedicated to the payment of benefits, such a measure would further mask the true level of the budget deficit.

The proposals would have an extremely negative impact upon the affected state and local governments, simply transferring part of the deficit from one level of government to the other.

While the impact of the mandatory Medicare proposal would fall most heavily upon governments in approximately 10 states (Alaska, California, Colorado, Illinois, Louisiana, Maine, Massachusetts, Nevada, Ohio, and Texas), forty-nine states include at least some subdivisions with non-covered employees that would be significantly harmed by these additional operating costs. Estimates of the annual costs to state and local governments are set forth state-by-state in Table B, attached. For example, each year, the proposal would cost governments in Illinois $78.1 million; in Ohio, $155.3 million; in Maine, $13.6 million, and in Texas, $126.9 million.

While the costs of the mandatory Social Security proposal are more difficult for us to calculate on a state-by-state basis, it should be noted that, since the inception of the Social Security system, students everywhere have been excluded from coverage for work performed for colleges or universities they are attending, and, from the time that states have been permitted to enroll their employees in the Social Security system, they have been permitted to exclude part-time workers from coverage. Thus it is safe to assume that the $2.1 billion that the Administration estimates this proposal would raise would have an adverse impact upon governments in many states.

Imposition of these additional costs would come at a difficult time. A recent study released by the National Conference of State Legislatures reports that more than one-half of the fifty states will face serious budget problems in 1990 for a variety of reasons, including slower-than-anticipated growth rates in the economy. At the same time, education costs are growing faster than revenues, while education funding responsibility is shifting to the states as pressure for property tax relief grows. Moreover, state and local governments have repeatedly been forced to shoulder additional burdens in recent years, resulting from considerable cuts in the Federal appropriations for many of their programs and the loss of revenue-sharing, while the Tax Reform Act of 1986 limited their ability to raise revenues, through loss of the sales tax deduction and new restrictions upon municipal bonds.

The result is that state and local governments are in no shape to absorb additional fiscal burdens. To cite a few examples of the results of this fiscal squeeze, a number of California counties have been required in recent years to close public libraries and parks as a result of budget shortfalls. In 1987, the President of the Board of Commissioners for Trumbull County, Ohio, testified that, as a result of the loss of revenue-sharing, 39,000 citizens in his county were without police protection. Governments at all levels around the country would find that imposition of the new 1.45% Medicare tax or the 6.2% FICA tax would force them to make very hard choices among essential services and staff.

President Bush has vowed to leave a legacy as "the Education President," leading the effort to improve the quality of education. Yet the mandatory coverage proposals would have a particularly adverse impact upon education in America.

Within the past several years, the National Commission on Excellence in Education declared that America's educational system is failing both its students and the entire country. It has been recognized that one cause is the difficulty school systems face in recruiting and retaining quality teachers. The Federal government has reported that the country will have 34% fewer teachers than it needs by 1992.

One reason for this problem is that teachers are significantly underpaid. In 1988-89, the average teacher's salary was $30,853, while the averages ranged state-by-state between $22,000 and $45,603.

Mandatory Medicare coverage would only exacerbate the problem caused by low salary levels. Teaching is one of the major professions with large numbers of non-

covered members. In the affected states, mandatory Medicare coverage would take an additional $447 from the average teacher's salary each year (1.45% of $30,853). As a result, many of the best qualified teachers—particularly those with marketable skills in mathematics, science, and computers—would leave teaching for better-paid employment.

The mandatory Social Security proposal would also have an extremely adverse impact upon education. First, the proposal would, for the first time, require students working part-time for the universities they are attending to pay 6.2% of their wages in new FICA taxes. For many students struggling to make ends meet, this could be enough to make further education no longer feasible. The measure would also impose an equally heavy new burden on the universities newly required to contribute 6.2% as the employer's share of FICA taxes, as well as upon the school systems employing substitute teachers required to be covered for the first time. In addition, the administrative cost of covering large numbers of people working relatively little, such as students and substitute teachers, would be quite burdensome.

In sum, in a time in which education is to take top priority, it would be unwise to adopt legislation that would aggravate the teacher recruitment problem and further increase the cost of education for both students and schools.

Mandatory coverage can not be justified on the grounds that it would benefit the affected employees.

In its budget, the Administration attempts to justify its Medicare coverage proposal in part with the paternalistic concern that mandatory Medicare "coverage of [all state and local] employees, who are the only major group of employees not assured Medicare [c]overage, would correct an inequity in coverage. . . ." Similarly, one justification for the Social Security proposal is that "[w]ithout social insurance protection, these workers and their families are vulnerable to loss of income due to death or disability, and are not earning credits for their retirement."

The response to this concern is simple: if public employees wanted Medicare and Social Security coverage, they would be clamoring for it. Since passage of COBRA, local jurisdictions have had the option of joining the Medicare system without also participating in the Social Security system. As for the Social Security proposal, states that have enrolled their employees in the Social Security system have had the option of also enrolling their part-time workers, while in many non-Social Security covered jurisdictions, workers who are not covered by a public plan have the option of participating in that plan. In short, if Medicare and/or Social Security coverage were desirable, employees would certainly bring pressure to bear upon their employers (which are, after all, elected governments) to adopt it. In fact, the opposite is true; far from clamoring for Medicare and Social Security coverage, public employee groups are vehemently opposed to efforts to impose these programs upon them. They do not need the Federal Government to provide these programs "for their own good."

II. PROBLEMS RELATING TO THE MANDATORY MEDICARE PROPOSAL

Mandatory Medicare coverage of the employees who were "grandfathered" outside the system by COBRA would create a variety of problems that were avoided by COBRA's compromise position.

Some state and local governments have health plans in place for their employees, including retirees. Adjustment of these plans to take account of Medicare coverage for existing employees would prove an overwhelming task, or would result in abandonment of these plans. While the phase-in provision adopted in COBRA affects the health benefits and take-home pay of individuals at the time they commence employment, the current proposal would displace benefits programs that individuals have enjoyed, in some cases, for many years, and would reduce the amount of take-home pay they have come to expect. Abandonment of the careful compromise adopted in COBRA would unfairly disappoint the expectations of millions of public workers.

III. PROBLEMS RELATING TO THE SOCIAL SECURITY PROPOSAL

The proposal would have the anomalous effect of requiring Social Security coverage of students of state colleges and universities, while allowing students attending private institutions to remain outside the system.

Since the inception of the Social Security system, students working for the college or university they are attending have been excluded from coverage. 412 U.S.C. §410(a)(10); I.R.C. §3121(b)(10). Part of the rationalization for this exclusion is that it "simplif[ies] administration," Sen. Report 1669 (May 17, 1950), given that relatively

large numbers of students work relatively few hours for their educational institutions. Another reason for excluding students from coverage is that keeping their tax burden to a minimum enables them to obtain an education and become more productive members of society. Presumably for these reasons, when the Administration proposed in 1987 to repeal the exclusion for students of all colleges and universities, the Congress rejected the proposal. The current proposal would affect only students attending state colleges and universities. Regardless of the reasons for covering students (and we do not believe that compelling ones exist), there can be no rational justification for distinguishing between students of public institutions and those attending private institutions.

The proposal would not provide retirement benefits to any significant class of individuals in need of coverage.

As explained above, virtually all of the employees who would be affected by this proposal are students or part-time or temporary employees. Almost all of the employees in these categories will eventually receive coverage under the Social Security system or under a public retirement system and thus are not in need of coverage. Indeed, those employees who join non-Social Security covered public retirement systems are likely to work such a short time in Social Security covered positions that, despite their contributions, they will not receive benefits.

Comparatively few part-time and temporary employees remain in these categories indefinitely. The majority of the affected individuals employed by schools (substitute teachers and part-time cooks and bus drivers) assume full-time positions and thus become covered by a public retirement plan. Seasonal workers in parks or on highway road crews generally obtain other employment at other times. Similarly, upon completion of their studies, the students who would be affected by the current proposal will choose careers either in Social Security-covered employment, in which case they will be covered by Social Security and possibly by an employer's retirement plan, or they will work in non-covered public employment, and will be covered by a state or local government plan. It is also important to note that, in many states, such workers are permitted (although not required) to join a public retirement plan. Thus the rare individual who chooses to work only as a substitute teacher may also choose to earn credit toward retirement benefits through such employment.

The proposal is also unfair because many of the people affected would be required to pay Social Security taxes but would not qualify for Social Security benefits. For the most part, this proposal would only affect people while they are in the work force for brief intervals. Assuming that the proposed legislation would be worded so that Social Security coverage lapsed at the point of coverage in a non-Social Security public retirement system, only a brief portion of a worker's employment would be covered by Social Security. Workers following this career path, as well as those who never work long-term (whether or not in the public sector), would be required to pay taxes but would not work long enough in covered employment to qualify for benefits—resulting in a clear windfall to the Federal government. It would be poor public policy to reduce the Federal deficit by applying the FICA tax to low- and middle-income workers who will never qualify for Social Security benefits.

For these reasons, we urge you once again to reject the proposals to impose mandatory Medicare and Social Security coverage upon state and local government employees.

Thank you for allowing me the opportunity to present the views of OPPOSE.

Attachments.

Table A.—ANNUAL COST TO STATE AND LOCAL GOVERNMENT EMPLOYEES OF MEDICARE COVERAGE OF ALL EMPLOYEES, MARCH 1990

State	Annual salary of average public employee [1]	Annual tax increase resulting from proposal [2]	Average tax decrease resulting from the tax reform act [3]
ALABAMA	$21,168	$307	$220
ALASKA	39,132	567	273
ARIZONA	27,276	396	220
ARKANSAS	18,564	269	200
CALIFORNIA	33,336	483	273
COLORADO	27,180	394	220
CONNECTICUT	30,900	448	273

Table A.—ANNUAL COST TO STATE AND LOCAL GOVERNMENT EMPLOYEES OF MEDICARE COVERAGE OF ALL EMPLOYEES, MARCH 1990—Continued

State	Annual salary of average public employee [1]	Annual tax increase resulting from proposal [2]	Average tax decrease resulting from the tax reform act [3]
DELAWARE	25,428	369	220
DIST. COLUMBIA	33,384	484	273
FLORIDA	24,552	356	220
GEORGIA	20,964	304	220
HAWAII	25,032	363	220
IDAHO	21,684	314	220
ILLINOIS	27,780	403	220
INDIANA	23,352	339	220
IOWA	24,456	355	220
KANSAS	22,200	322	220
KENTUCKY	20,568	298	220
LOUISIANA	20,016	290	220
MAINE	22,008	319	220
MARYLAND	29,220	424	220
MASSACHUSETTS	28,128	408	220
MICHIGAN	30,300	439	273
MINNESOTA	29,508	428	220
MISSISSIPPI	17,844	259	200
MISSOURI	22,800	331	220
MONTANA	22,068	320	220
NEBRASKA	22,956	333	220
NEVADA	26,952	391	220
NEW HAMPSHIRE	23,556	342	220
NEW JERSEY	29,184	423	220
NEW MEXICO	20,964	304	220
NEW YORK	31,368	455	273
N. CAROLINA	23,004	334	220
N. DAKOTA	23,856	346	220
OHIO	25,428	369	220
OKLAHOMA	20,148	292	220
OREGON	25,632	372	220
PENNSYLVANIA	25,728	373	220
RHODE ISLAND	28,392	412	220
S. CAROLINA	21,096	306	220
S. DAKOTA	19,320	280	200
TENNESSEE	20,784	301	220
TEXAS	22,512	326	220
UTAH	22,308	323	220
VERMONT	23,280	338	220
VIRGINIA	24,636	357	220
WASHINGTON	27,456	398	220
W. VIRGINIA	19,812	287	200
WISCONSIN	26,880	390	220
WYOMING	23,664	343	220

[1] U.S. Bureau of the Census, Public Employment in 1988—Government Employment (Series GE–88–1) at 10.
[2] The amount of the new Medicare tax is derived by multiplying the average employee's salary by 1.45%.
[3] Joint Committee on Taxation Staff, Data on Distribution by Income Class of Effects of H.R. 3838, Tax Reform Act of 1986 (JCX–28–86) (October 1, 1986), Table 4.

Table B.—ANNUAL COST TO STATE AND LOCAL GOVERNMENTS OF COVERAGE OF THOSE EMPLOYEES CURRENTLY NOT COVERED BY MEDICARE, MARCH 1990

State	Employees not covered by Social Security [1]	Employees not covered by Medicare		Cost of coverage (in millions of dollars) [3]
		Number [2]	Percentage [2]	
ALABAMA	27,000	18,522	7.55	$7.0
ALASKA	40,000	27,440	47.33	10.4
ARIZONA	21,000	14,406	7.55	5.5
ARKANSAS	39,000	26,754	8.92	10.2
CALIFORNIA	991,000	679,826	43.22	258.7
COLORADO	150,000	102,900	52.14	39.2
CONNECTICUT	63,000	43,218	25.38	16.4
DELAWARE	14,000	9,604	23.32	3.7
FLORIDA	127,000	87,122	14.41	33.2
GEORGIA	64,000	43,904	12.35	16.7
HAWAII	24,000	16,464	22.64	6.3
IDAHO	0	0	0	0.0
ILLINOIS	299,000	205,114	32.93	78.1
INDIANA	54,000	37,044	11.66	14.1
IOWA	5,000	3,430	1.37	1.3
KANSAS	2,000	1,372	0.69	0.5
KENTUCKY	56,000	38,416	18.52	14.6
LOUISIANA	271,000	185,906	58.31	70.7
MAINE	52,000	35,672	48.71	13.6
MARYLAND	29,000	19,894	6.86	7.6
MASSACHUSETTS	334,000	229,124	68.6	87.2
MICHIGAN	19,000	13,034	2.74	5.0
MINNESOTA	96,000	65,856	22.64	25.1
MISSISSIPPI	2,000	1,372	0.69	0.5
MISSOURI	62,000	42,532	15.09	16.2
MONTANA	5,000	3,430	6.17	1.3
NEBRASKA	2,000	1,372	1.37	0.5
NEVADA	49,000	33,614	64.48	12.8
NEW HAMPSHIRE	6,000	4,116	6.86	1.6
NEW JERSEY	30,000	20,580	4.12	7.8
NEW MEXICO	33,000	22,638	18.52	8.6
NEW YORK	153,000	104,958	8.23	39.9
N. CAROLINA	43,000	29,498	7.55	11.2
N. DAKOTA	6,000	4,116	6.86	1.6
OHIO	595,000	408,170	68.6	155.3
OKLAHOMA	33,000	22,638	10.29	8.6
OREGON	14,000	9,604	4.8	3.7
PENNSYLVANIA	36,000	24,696	4.12	9.4
RHODE ISLAND	25,000	17,150	29.5	6.5
S. CAROLINA	6,000	4,116	2.06	1.6
S. DAKOTA	2,000	1,372	3.43	0.5
TENNESSEE	29,000	19,894	8.23	7.6
TEXAS	486,000	333,396	34.3	126.9
UTAH	1,000	686	0.69	0.3
VERMONT	1,000	686	1.37	0.3
VIRGINIA	72,000	49,392	12.35	18.8
WASHINGTON	36,000	24,696	8.92	9.4
W. VIRGINIA	7,000	4,802	4.12	1.8
WISCONSIN	48,000	32,928	10.98	12.5
WYOMING	5,000	3,430	6.86	1.3
TOTAL	4,564,000	3,130,904	.....	$1,191.4

[1] Social Security Administration, 1985 Current Population Survey and Continuous Work History Sample, *reprinted in* Congressional Research Service paper "Medicare Coverage of Employees of State and Local Governments," by David Koitz, (March 11, 1987).

[2] The Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, requires public employees hired after March 31, 1986, to participate in the Medicare system. Because we assume employee turnover occurs at a rate of approximately 9% per year, in the four years since COBRA took effect, approximately 31.4% of previously non-covered public employees are now covered by Medicare. The number of public employees not covered by Social Security has therefore been reduced by 31.4% to reflect the number of employees who are currently not covered by Medicare.

[3] The figures reflect only the 1.45% that would be paid by the governments as employers, and do not include the cost increase to their employees, who would also have to pay the 1.45% Medicare tax. (See reverse side for increased tax burden on individual employees.) Given that

the employer's part of the Medicare tax is 1.45%, and the salary of the average state or local government employee is $26,244 (U.S. Bureau of the Census, Public Employment in 1988—Government Employment (Series GE–88–No. 1) at 10), each governmental employer's cost is equal to the number of employees, multiplied by $26,244, multiplied by 1.45%.

Statement of the U.S. Chamber of Commerce

The U.S. Chamber of Commerce appreciates this opportunity to express its views on the President's Fiscal Year 1991 (FY '91) Revenue Proposals.

TWENTY-FIVE PERCENT DEDUCTION FOR HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS

Section 162(1) of the Internal Revenue Code provides that self-employed individuals may deduct 25 percent of the amount paid for health insurance for the individual, the individual's spouse, and dependents. This provision was added to the Code in 1986 to make the tax treatment of health insurance benefits of self-employed individuals fairer and to encourage broader coverage in this sector.

The Chamber supports permanent extension of this tax deduction for the self employed and supports increasing the deduction to 100 percent. Unincorporated small business owners should have a full deduction in order to have parity with their competitors who are organized as corporations and are thus able to take advantage of full deductibility of health insurance costs.

Many of the individuals affected by this provision are self-employed small business owners, who provide jobs for more than 20 million Americans. But these business owners also represent a significant portion of the uninsured population. The Employee Benefit Research Institute estimates that 22 percent of self-employed business owners do not have health insurance coverage.

Several factors are responsible for this gap in coverage. Last year, most employers were faced with double-digit inflation in the costs of their health plans. This latest wave has hit small businesses particularly hard. Health insurance premiums for small companies run 10–15 percent higher than those in large firms, because there are fewer people among whom to spread risk and the administrative costs are higher for individuals and small groups. Indeed, if this deduction is allowed to expire, those who use the deduction could be faced with increases of as much as 8.25 percent in the after-tax cost of their health insurance premiums.

Today more than 136 million Americans have coverage through corporate employer-provided plans. The Chamber believes that other forms of business organizations, e.g., sole proprietorships and partnerships, should have the same incentive—100 percent deductibility—that is given to corporations to provide health insurance.

At a time when the nation is more aware of the growing problem of the uninsured and the socketing costs of health coverage, it makes no sense to allow this important tax deduction to lapse. Indeed, from a health policy perspective, the 25 percent deduction not only should be retained but also should be expanded to 100 percent. This is not the only remedy that is needed to increase health-care coverage, but it would be an important step.

USE OF EXCESS PENSION FUND ASSETS TO FUND RETIREE HEALTH CARE PLANS

The Chamber believes that employers should be permitted to use excess pension plan assets to fund a retiree health care plan. This should occur as a transfer from an ongoing pension plan, without requiring pension plan termination, forcing the annuitization of pension benefits, or triggering adverse tax consequences. A determination should be made that assets adequate to support benefits, with reference to termination liability, remain in the pension plan. Vesting and accrual standards modeled on pension plan regulation should not be extended to retiree health plans. Employers should retain the right to amend or terminate retiree health care plans in accordance with plan documents.

RESEARCH AND EXPERIMENTATION TAX CREDIT

Industrial progress depends on the development of innovative products and methods. Research and experimentation (R&E) conducted by business is the primary means by which innovation is generated. Scientific developments are transformed into new products and processes that result in increased productivity, improved living standards, and sustained economic growth.

According to the Administration's FY '91 budget, the Federal Government funds about 50 percent of total national investment in R&E. However, almost 90 percent

of total national R&E is performed by nongovernmental entities. Industry performs 72 percent of total national R&E.

These statistics highlight the Chamber's view that a successful national R&E policy is best served through reliance on private R&E expenditures. President Bush recognizes the significant role of the private sector in R&E. This is demonstrated by the Administration's call for a permanent R&E tax credit. Although it was later dropped in conference, the Chamber was pleased that the House Committee on Ways and Means included a permanent R&E credit as part of its FY '90 budget reconciliation bill.

A permanent R&E credit is necessary to ensure that the U.S. remains the largest investor in absolute size regarding R&E expenditures and to ensure that American business remains competitive overseas. A 1989 National Science Foundation report on national R&E resource patterns indicates that the U.S. spends more money on R&E activities than France, West Germany, the United Kingdom and Japan combined.

These statistics mask the real trends on an international basis. For example, although the same National Science Foundation report states that U.S. R&E expenditures (on a combined civilian and defense basis) were roughly comparable to West Germany and Japan's expenditures as a proportion of Gross National Product (GNP) during the late 1980s, the statistics dramatically diverge when compared on a civilian R&E basis. On a civilian basis, the U.S. spent about 1.7 percent of GNP on R&E during the same period. In contrast, Japan and West Germany spent approximately 2.8 percent and 2.6 percent of GNP, respectively, on civilian R&E in the late 1980s.

Other National Science Foundation statistics elaborate on the international competitiveness issue. The U.S. had the highest proportion of scientists and engineers engaged in R&E per 10,000 population until the mid-1980s. From 1964 to 1985, the U.S. had roughly 64.7 scientists and engineers per 10,000 population. In contrast, Japan nearly tripled the number of these technical professionals in its population during the same period. By 1986, Japan had 67.4 scientists and engineers per 10,000 population, while the U.S. had 66.2 scientists and engineers on a similar proportionate basis. West Germany has more than doubled its percentage of these technical persons on a population basis since the mid-1960s as well.

The research credit is an important component of a productivity growth strategy, especially when weighed against the dramatic slowdown in the rate of productivity growth beginning with the mid-1960s, and which became progressively worse from 1973 to 1981. According to U.S. Patent Office statistics, there is evidence that innovation slowed between 1973 and 1981. These statistics indicate that the number of patents issued to U.S. inventors fell from a high of more than 50,000 per year from 1971–1973 to approximately 35,000 per year in the early 1980s. Patents issued to U.S. inventors have increased in recent years, as suggested by the fact that U.S. inventors were issued about 47,500 patents in 1987.

There is a virtual consensus that rapidly growing R&E is a prerequisite of rapid productivity growth. John W. Kendrick, a recognized expert on productivity with the American Enterprise Institute, has emphasized that the slowdown in R&E spending was a major contributor to the decline of productivity growth from the mid-1960s through 1981. By enacting the R&E tax credit into law in 1981, Congress recognized the need to maintain U.S. competitiveness with major trading nations and the importance of reversing the dismal productivity trends of previous years.

Corporate R&E spending produces benefits to society as a whole beyond the private rewards reaped by the companies involved in the R&E operation. The excess social gains accrue both to consumers and to firms that compete with the companies conducting the R&E. Consumers benefit from lower prices on products as a result of cost-saving innovations and from the availability of new products. Competing firms are able to develop their own applications of innovative technology.

There is a substantial gap between the social and private rates of return for R&E and innovation. As a result, without an incentive such as the R&E tax credit, businesses will spend less in the U.S. on R&E than would be desirable from the perspective of society as a whole. The nation's R&E shortfall cannot be cured in a short period. R&E is inherently long-range. In industries such as electronics, product cycles can last three to five years. Each cycle also builds on earlier cycles. In other high-technology industries, such as aerospace, product cycles can last 10-15 years. In either case, high levels of R&E efforts must be performed every year. American industry is committed to undertaking the necessary efforts. But to enable this, it needs sensible and stable policies.

To maximize the benefits from the R&E tax credit for both businesses and society as a whole, the Chamber urges making the credit permanent. The uncertainty sur-

rounding the future existence of the credit no doubt leads to businesses reducing their commitment to long-term R&E projects and, in turn, reduces the social benefits from R&E spending to all Americans.

ALLOCATION OF U.S. R&E TO FOREIGN SOURCE INCOME

A U.S. corporation's foreign tax credit is limited to 34 percent of the company's foreign source taxable income. Sections 861, 862, and 863 of the Internal Revenue Code were created to define whether the source of income was within or outside the U.S. Treasury Regulation Section 1.861-8 requires that indirect expenses be apportioned to the sources of income. Presumably, if this defining process is properly carried out, that which is U.S. source income will be taxed in the U.S. and that which is foreign-source income will be eligible for the relief provided by the foreign tax credit mechanism.

The allocation of indirect expenses to foreign-source income, without a corresponding foreign deduction, has the inherent effect of taxing the same earnings twice if a corporation runs up against its foreign tax credit limitation. Under the Tax Reform Act of 1986, it is more probable that multinational corporations will e in that situation. This result, of course, defeats the very purpose of the foreign tax credit, which is to prevent double taxation.

Double taxation results or can result, depending on the particular circumstances, because the U.S. expenses that are allocated under the Section 1.861-8 regulations to foreign-source income are not deductible in a foreign jurisdiction. Other nations do not allow a deduction of indirect expenses incurred by another entity. Thus, a U.S. taxpayer in effect has his foreign tax credit limitation proportionately reduced to the extent that it conducts U.S. R&E.

The Chamber believes that R&E expenses incurred in the U.S. should be 100 percent allocated to U.S.-source income. Nevertheless, the Chamber does view President Bush's proposal for a permanent solution to the matter of allocating U.S. R&E to foreign-source income as a positive approach. This proposal provides for allocation of 64 percent of R&E expenses to the U.S.

IRS USER FEES

Section 10511 of the Revenue Act of 1987 provides the Secretary of the Treasury (or his delegate) with the authority to require user fees for IRS rulings, opinion letters, determination letters, and for certain other filings made with the Internal Revenue Service after January 31, 1988 and before October 31, 1990. President Bush has proposed that this authority be extended permanently, as recommended in the Administration's FY '91 budget proposals. In light of the IRS's announcement on March 1, 1990 to increase the user fees for various ruling requests and tax filings, the Chamber is concerned about the Administration's proposal to extend permanently the Department of the Treasury's authority to impose user fees for such tax filings.

There is an important distinction to be drawn between forms that must be filed to comply with the law and requests for advice or rulings that are not necessary in order to comply with the law. Fees that must be paid to file forms that the law requires are not user fees in any meaningful sense of the word. They are taxes. However, fees paid for so-called comfort rulings and the like are genuine user fees and should be analyzed as such.

AVIATION USER FEES

The Chamber strongly supports the user fee-financed trust fund approach to providing resources for transportation infrastructure programs. Current and projected growth in air travel and air freight markets will require significant increased investment in the nation's aviation infrastructure. The traveling public and users of air freight services are currently paying billions of dollars in user fees for an inadequate aviation system. At the same time, the Federal aviation trust fund has accumulated a $7 billion surplus by underinvesting in needed facilities. The Administration has proposed increasing the passenger ticket tax from 8 to 10 percent and other user fees will rise commensurately. These increases are proposed in conjunction with a plan to begin drawing down the aviation trust fund to $3 billion by FY '95.

The private sector is willing to pay its fair share for aviation infrastructure costs and the operation and management expenses of the Federal Aviation Administration. In addition, the Chamber supports allowing local airport authorities to increase local resources for improving airports through reasonable passenger facilities charges.

However, until the Federal Government restores its credibility as a responsible partner in meeting the nation's infrastructure need by first drawing down current trust fund surpluses and establishing a system for preventing future abuses of user fee revenues, the Chamber cannot support further increases in Federal aviation user fees. Congressman Norman Y. Mineta capsulized the current position of many in the aviation community in his March 5, 1990 letter to The New York Times when he said: "No new aviation taxes—and let's either spend the ones we've got, as we said we would, or shut down the till."

This position reflects the growing frustration on the part of consumers and the business community with a policy that leads to increasing transportation trust fund balances while the nation's transportation infrastructure crumbles.

SOCIAL SECURITY

President Bush has proposed, when his proposal is stripped to its essence, that the U.S. gradually begin running a unified budget surplus. He would retain the Gramm-Rudman-Hollings framework for years beyond FY '93. When fully phased in by FY '96, the unified budget would be running a surplus equal to the Social Security trust fund surplus of about $138 billion annually.

This proposal is meant to increase the national savings rate in order to promote economic growth and make it easier to fund the retirement of the baby-boom generation. However, the Chamber believes that this reasoning is flawed. Taxing the private sector to pay down the national debt would have the effect of slowing the growth of the GNP and making Social Security a heavier burden on future taxpayers. In addition, the higher taxes necessary to retire the national debt would raise the cost of capital and labor, depending on which taxes were kept high, and reduce the competitiveness of American industry in the international marketplace.

The Chamber urges Congress to reduce the Social Security payroll tax and to ensure that the payroll tax reduction is matched by equal and offsetting spending reduction. To ensure responsible budget policy and to ensure that the entire Social Security surplus is returned to taxpayers by spending restraint, the Gramm-Rudman-Hollings framework should be extended beyond FY '93. This approach will promote economic growth. The President's unified budget surplus plan, in contrast, will impede economic growth and make it more difficult to fund the retirement of the baby-boom generation in the long run.

PAYROLL TAX DEPOSIT RULES

The Chamber is concerned about the compliance burdens that the business community is likely to face from the payroll tax deposit speedup provision, contained in the FY '90 budget reconciliation legislation.

Under the FY '90 budget reconciliation package, employers are required to deposit payroll taxes with a Federal depository by the close of the applicable banking day (instead of by the close of the third banking day) after any day on which payroll deposit accruals are at least $100,000. The effective date of the provision is for amounts required to be deposited after July 31, 1990. For purposes of the new law, the applicable banking day is the next banking day for 1990, the second banking day for 1991, the third banking day for 1992, and it reverts to the next banking day for 1993 and 1994.

President Bush's FY '91 budget recommends that the payroll tax deposit rules for affected employers be made consistent for all years, which means that payroll deposits would be required to be made by the close of the next banking day.

The apparent rationale for requiring a payroll deposit speedup is that businesses should be able to comply easily with a measure of this type, especially when sophisticated computer hardware and software are generally available. However, even for large firms this is a difficult task, particularly if payroll accounting is done at more than one location.

The FY '90 budget legislation, as well as President Bush's proposal, will exacerbate the compliance burdens of businesses. As the payroll deposit threshold amount is steadily decreased, smaller and smaller enterprises will be forced to comply with payroll tax deposit rules based on an unrealistically fast pace. These firms are already plagued by an extremely complex Federal tax system. Small businesses, which constitute the majority of Chamber members, consider the payroll tax deposit procedures to be some of the most complicated requirements under tax law and regulations.

The business community, Congress, and the Administration should be seeking ways to reduce the compliance burdens placed on the taxpaying public. Therefore, the Chamber recommends that the Administration's payroll deposit speedup. pro-

posal be opposed and that Congress enact legislation that would return to the procedure of generally requiring employers to make payroll tax deposits with a Federal depository by the close of the third banking day.

ENTERPRISE ONES

The Chamber supports the Administration's enterprise zone proposal because it represents a carefully circumscribed program that will enable policy makers to gauge the actual impact of the zones on depressed communities. Enterprise zones offer a constructive approach to solving the problem of promoting economic growth in depressed areas. But they present a number of potential problems that need to be closely monitored before a final determination can be made on their desirability.

Thank you.

STATEMENT OF THE WINE AND SPIRITS WHOLESALERS OF AMERICA, INC.

The undersigned alcohol beverage organizations appreciate the opportunity to present testimony for the record in connection with hearings held on March 6, 1990, regarding revenue provisions contained in the Administration's budget for fiscal 1991:

The Administration's FY 1991 budget proposes to eliminate existing special occupational taxes on alcohol retailers and shift and increase the tax assessment to suppliers and wholesalers. Our industry is united in opposition to this proposal to relieve retailers at the expense of wholesalers, producers, and ultimately the consumer.

As part of the 1987 Omnibus Reconciliation Act, special occupational taxes were first levied on suppliers ($500 for licensees with gross receipts of less than $500,000 and $1,000 for all others) and increased for wholesalers and retailers (from $54 to $250 for retailers, from $250 to $500 for wine and spirits wholesalers, and from $123 to $500 for beer wholesalers). The Bureau of Alcohol, Tobacco and Firearms (BATF) was mandated to enforce the law and, due to past noncompliance by many retailers, began assessing back taxes, penalties and interest. As a result, many Congressmen were alerted to the problem by their retailer constituents and the tax-writing committees examined the issue.

In 1989, the Senate Finance Committee approved an amendment to lower the retail tax for smaller retailers to $150 and provide a statute of limitations for back taxes. The Committee did not shift the tax to suppliers and wholesalers. A proposal before the House Committee on Ways and Means to make such a shift was never considered.

The Administration has now gone even further-proposing to completely eliminate the tax on retailers and place the entire burden on suppliers and wholesalers. The Office of Management and Budget (OMB) has a target collection of $190 million—$60 million more than is now being collected.

Brewers, distillers, vintners, importers and wholesalers of beverage alcohol are united in their opposition to any proposal to increase and shift the burden of the special occupational tax at the expense of wholesalers, suppliers, and consumers.

There is absolutely no justification for shifting occupational taxes to suppliers and wholesalers. We are law-abiding citizens who already have an almost 100 percent rate of tax compliance. It is unfair to make us pay more taxes in order to cover the approximately 40 percent non-compliance of others. By shifting the tax, OMB is penalizing those who have complied by instituting an *additional* tax upon suppliers and wholesalers.

While at this writing the specifics have not been formally announced, the OMB proposal would be much more draconian than any proposal considered last year. Every wholesaler and supplier license assessment could increase from $500 or $1,000 to a minimum of $19,000 if all 10,000 licensees were assessed equally. For wholesalers and smaller suppliers, the $19,000 permit fee would be a 3700 percent increase. For larger suppliers, the $19,000 fee would be an 1800 percent increase. Many suppliers and wholesalers hold more than one license and thus would be assessed for each one. Such situation would be further exacerbated in that hundreds of small family owned wineries, distillers, brewers, and wholesalers will be forced out of business thereby decreasing the number of licenses and even further increasing the burden for those remaining.

During the first session of the 101st Congress, the Senate Finance Committee rightfully refused to consider raising supplier and wholesaler taxes to provide retail tax relief. In the House Committee on Ways and Means, a proposal to lower retail taxes and raise wholesaler and/or supplier taxes met with stiff opposition from

members and all segments of the beverage alcohol wholesaler and supplier community.

While tavern owners and liquor store owners would benefit by elimination of the retail tax, their Washington representatives (the National Licensed Beverage Association and the National Liquor Store Association) do not support the Administration special occupational tax proposal to shift and increase the burden. In testimony before the House Committee on Ways and Means last year, the National Restaurant Association, which also supported the elimination of the retail tax, urged Congress not to reduce retail taxes at the expense of suppliers and wholesalers.

Brewers, distillers, vintners, importers and beer, wine and spirits wholesalers have united to oppose the imposition of additional financial burdens over already burdensome state, local and federal tax obligations. However, we not not oppose appropriate tax relief for retailers. An alternative proposal for this relief could incorporate an amnesty period, a statute of limitations and the creation of a special tier to address the tax inequity placed on small businesses.

Thank you.

BEER INSTITUTE
DISTILLED SPIRITS COUNCIL OF THE UNITED STATES
NATIONAL BEER WHOLESALERS ASSOCIATION
NAT'L. ASSOCIATION OF BEVERAGE IMPORTERS
WINE AND SPIRITS WHOLESALERS OF AMERICA
WINE INSTITUTE
ASSOCIATION OF AMERICAN VINTNERS
NATIONAL WINE COALITION